IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF NORTH CAROLINA

CIVIL ACTION NO. 3:22-cv-00191

KANAUTICA ZAYRE-BROWN,)
)
Plaintiff,)
)
vs.)
)
THE NORTH CAROLINA)
DEPARTMENT OF PUBLIC)
SAFETY, ET AL.,)
)
Defendants.)

DEPOSITION OF

SARA BOYD, PH.D.

9:08 A.M.

FRIDAY, AUGUST 4, 2023

NORTH CAROLINA DEPARTMENT OF JUSTICE

114 WEST EDENTON STREET

RALEIGH, NORTH CAROLINA

CONTAINS GENERAL CONFIDENTIAL INFORMATION

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I N D E X

E X H I B I T S

P R O C E E D I N G S

* * * *

SARA BOYD, PH.D.,

having been first sworn or affirmed by the court reporter and Notary Public to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. SIEGEL:

Q. All right. Dr. Boyd, good morning.

A. Good morning.

Q. Thank you for being here. We met just a minute ago, but I'll reintroduce myself for the record. My name is Dan Siegel and I'm one of the lawyers with the ACLU representing Kanautica Zayre-Brown --

A. Uh-huh.

Q. -- who's the plaintiff in this lawsuit. I'll be taking your deposition today. Before we get started, just a few housekeeping items to get out of the way.

First, just need to acknowledge for the record that since this lawsuit began, the North Carolina Department of Public Safety or DPS had a -- a reorganization and now the

defendant in this case is known as the North Carolina Department of Adult Corrections or DAC. So for purposes of this deposition, if I refer to DPS or DAC, I'm referring to the state prison system, the --

A. Right.

Q. -- defendant in this case.

Does that make sense?

A. Yes.

Q. Okay. Have you ever been deposed before?

A. Yes.

Q. About how many times?

A. I don't -- maybe -- over ten times, probably.

Q. Okay. So this will all just be review, but I'm going to set out some --

A. Uh-huh.

Q. -- ground rules to help maybe move -- make this go a little -- as smoothly as possible, to make the court reporter's job a little easier. First, I would just ask that you answer all of my questions verbally instead of giving an uh-huh or an uh-uh or shaking or nodding your head and any other kind of nonverbal response.

Does that make sense?

A. Yes.
Q. Okay. Great. The court reporter is taking everything down so I would just ask that you allow me to finish my question before you begin your answer and, likewise, I will do my best to let you finish your answer before I an- -- ask my next question.

Make sense?

A. Yes.

THE WITNESS: I would also note that sometimes I have a tendency to speak quickly so if at any point I'm speaking too quickly, please let me know.

BY MR. SIEGEL:

Q. If you do not understand a question that I ask or you don't think you heard me quite right or you need me to repeat it, please just go ahead ask. I do not mind at all. If you do answer my question, I will assume that you heard it and understood it, okay?

A. Okay.

Q. We're going to be taking breaks throughout the day. If there's ever a point when it's not a designated break time and you would like to take a break, that's totally fine.

We can do that. I would just ask that you answer whatever question I had just asked before we break.

A. Yes.

Q. Is that all right? Okay. During the deposition your attorney is probably going to object to some of the questions that I ask. Unless he specifically instructs you not to answer the question, once he finishes his objection, you will need to go ahead and answer the question.

A. Yes.

Q. Does that make sense? Okay. The court reporter administered the oath to you a moment ago. You assented to that meaning you are under oath for the entirety of this deposition. It's the same as if you were testifying under oath in a courtroom, which means you must testify -- excuse me, testify truthfully.

Do you understand?

A. Yes.

Q. All right. Is there any reason you cannot testify truthfully today?

A. No.

Q. And if you recall additional information responsive to any of my questions later on in the deposition, please just let me know and we can go over it, all right?
A. Okay.
Q. Okay. So what did you do to -- if anything, to prepare for this deposition today?
A. I rereviewed some materials that I had already reviewed prior just to refresh my recollection. The materials included the materials that I listed in my report including medical records; the deposition; my own -- my own report; and, oh, Dr. Ettner's declarations.
Q. Did you bring any documents with you today?
A. I have a copy of my own report that was submitted.
Q. Anything else?
A. Not with me, no.
Q. Okay. Have you ever been sued before?
A. No.
Q. Other than expert witness work, have you ever been involved in other lawsuits?
A. No.
Q. Okay. All right. So I'm going to go ahead

and give you an exhibit which we'll mark as Exhibit 1, please.

(BOYD EXHIBIT 1, Curriculum Vitae, was marked for identification.)

BY MR. SIEGEL:

Q. You'll see that this is your résumé or your CV --

A. Thank you.

Q. -- that you provided earlier in this case. Would you please just take a look at it and let me know if this is up to date.

A. I think there are -- so there have been two updates to this, both of which are publications, that I'm not seeing here. One is the book chapter which I think you -- which is, I think, going to be in press in September.

Q. Okay.

A. And the other is a -- a journal article about threat assessment that doesn't have anything to do with trans folks --

Q. Okay.

A. -- or correctional settings specifically.

Q. All right.

A. Those are the only two things that I can

see --

Q. Okay.

A. -- are -- are updated.

Q. All right. Thank you. Could you just walk me through your educational background.

A. Certainly. I have a bachelor's degree in psychology from the University of Illinois. I have two master's degrees, one in counseling psychology, one in clinical psychology. I have a certi- -- graduate certificate in developmental disabilities. I have a Ph.D. in clinical psychology from the University of Kentucky. I did a -- a postdoctoral fellowship in forensic psychology at the University of Virginia and I'm board-certified as a forensic psychologist with the American Academy of Professional -- sorry, American Academy of Professional Psychology.

Q. Okay. In your academic studies, did you have any particular focus on any particular subject matter?

A. Early on. So the -- the focus was primarily on folks with developmental disabilities and interpersonal trauma so primarily sexual and

domestic violence work. That was mostly in a treatment capacity and I was also a direct service provider, like a caregiver kind of role. Then in graduate school in the course of my first master's program, I started doing more forensic work specifically on the victim side in criminal cases and then I shifted to a forensic focus. So midway through my first master's degree was when I shifted to a primarily forensic focus.

And then when I completed my Ph.D., my dissertation and my master's were both about intellectual disabilities and personality functioning. So those were the two areas was personality and -- and intellectual developmental disabilities, but I started completing my forensic training in earnest around the end of my Ph.D. when I was doing training rotations in psychiatric units in forensic hospitals. Excuse me. And then I did forensic training in New York as part of my predoctoral fellowship. The postdoctoral fellowship was entirely forensic. It's not required, but it's something that I did in part to make sure that I had a sufficient

depth and breadth of knowledge to practice competently as a forensic evaluator partly because my early focus had not been forensic. And since then, you know, I also completed the board certification, again, to bolster my knowledge in terms of the forensic area.

So in recent years, it's been primarily -- well, I'm exclusively forensic in my practice. Most of my work focuses on -- sexual/gender minority populations, intellectual developmental disabilities, and interpersonal trauma I would say are the -- kind of the three big areas.

Q. Okay. And this is perhaps a dumb question, but can you just define forensic for me.

A. Yeah. So forensic in -- in -- in psychology, it means the application of psychological science to help triers of fact answer questions related to legal or quasi legal matters. So it's not always actually a -- like a criminal or civil context. It could be an administrative proceeding or something like that as well.

Q. Okay. In your studies, did they involve anything with transgender individuals or

gender dysphoria?

A. Yes. So when I was in my counseling psychology program, one of my professors had a specific interest in the fluidity of both sexuality and gender over life span and so I had a gender development coursework, which is, you know, really kind of the framework that a lot of us think within now as a gender development kind of mind set about these things.

Additionally, I -- when I was on my forensic postdoctoral training at UVA, my colleague was somebody -- Eugene Simopoulos, who published extensively and was doing evaluations for -- they were independent evaluations for incarcerated transgender folks in the Virginia DOC. So they would hire independent psychologists to come in and do an evaluation and that is when I actually became -- became involved in doing evaluations of folks where it wasn't, like, incidental, right. It -- before that, I had certainly encountered transgender and gender diverse folks where that wasn't the central question; that was just part of the -- their

identity when they came in for a competency evaluation or something like that, but that's when we began to -- I began to focus more on doing the evaluations that are focused specifically on gender. Around that time, you know, he was also publishing some papers in that regard. I did not publish with him, but I was certainly reading up on it. We also have another individual in our area, Michael Hendricks, who assisted in writing the APA's gender treatment-related guidance from 2015.

So I had the professional associations with those folks and that's when I began doing more of the evaluations that were really -- where the question related to the -- to somebody's gender and what they wanted to do in terms of treatment.

Q. And what year was that when you started doing these evaluations?

A. When I started doing the evaluations on incarcerated people, specific to issues related to gender would have been around, I think, 2013.

Q. Okay. And that was part of your fellowship;

is that right?

A. Yes.

Q. Okay. And you said you were doing gender dysphoria evaluations, I -- I think?

A. Yeah. So it's interesting. The referral questionnaire wasn't very clear a lot of the time. It was just, we need an independent evaluation of this person. And I noticed that some of the evaluators were treating the evaluation as a question of whether or not the individual was, in fact, transgender and that, in my view, is not an appropriate question for that evaluation. It was more what does this person need and do they need support.

So the evaluations that I wrote were different from my colleagues. I -- I don't want to make it seem like I just, you know, learned from their type of practice and adopted that. I started doing things slightly differently around that time, but I was doing my own independent evaluations through the Virginia Department of Corrections where they would contact me to do those independent evaluations. And

typically, I did make recommendations about what kind of intervention I thought the person ought to receive, but typically, it was, you know, more looking at did the person have issues with literacy or their cognitive functioning or something like that where they just might need help in understanding what their options were.

Q. What kinds of interventions would you recommend?

A. Most of the people that I was getting referrals for were very early in terms of -- they were not seeking very difficult kinds of modifications. They wanted things like access to boxer briefs or certain kinds of deodorant so essentially cosmetic items. There were some people who wanted to have -- ultimately described wanting to have surgical procedures, access to hormone treatment -- endocrine management, I should say, and for most of those folks, the question for me was not should they have those things. It was just, you know, do they understand, do they have the capacity to -- to reason about those things and do they need support.

So, for example, one person did have an intellectual disability, very low IQ and very limited literacy, and all that person wanted was the cosmetic kind of -- and -- and garments, really. So that was a very easy one, you know, to say, well, this person is going to need -- if they do want to do more difficult interventions, they're probably going to need more support and don't just give them a written handout because they can't read. So it wasn't saying they shouldn't get those things and my understanding is they ultimately did get those things. But the -- the issue was more how could this person be accommodated given their impairments so that they could continue to move through that process to seek whatever accommodations they felt were appropriate and good for them.

Q. Okay. Is there anything else about your educational background that you think is just important to know for, you know, understanding your career?

A. If you'll give me a moment to just glance through my own CV to --

Q. Sure.
A. -- refresh my recollection. I want to make sure I'm thorough. So the only other thing that's potentially relevant related to my educational history is that I was one of the founding memer -- members of our graduate school -- what they ended up calling a diversity committee. And my role specifically on that panel was to be a graduate student representative and my particular area of diversity that they asked me to offer input about was related to LGB key -- LGBTQAI [sic] or what we call sexual gender minority issues for that panel. So in that regard, I was advising my own graduate program of how they might do a better job of not just providing training to graduate students but also recruiting sexual and gender minority graduate students to ultimately become students and practitioners.
Q. Got it. Anything else?
A. No.
Q. Okay. I'd like to turn to -- there's a lot here. Where is it? -- your publications, which is on Page 7.

A. Yes.
Q. There's a -- a lot here so no need to take you through all of them. My question is, do any of the publications listed here concern gender dysphoria?
A. I do not believe so.
Q. Okay. And please take a moment --
A. Yes.
Q. -- if you'd like.
A. No, I do not believe so.
Q. Okay. You did reference you have a -- you're a coauthor of a book chapter.
A. Yes.
Q. And I believe it's concerning Psychological Evaluation, Management, and Treatment of Transgender and Gender Diverse People in -- Housed in Correctional Settings; is that right?
A. Yes.
Q. Okay. Can you just tell me about what the -- what -- what is this book chapter?
A. Yeah. Yeah. So I was invited to coauthor this book chapter. The author -- the other authors include Walter Campbell, who is a correctional psychologist in Idaho; Sarah

Miller, who's a forensic psychologist who works for the State in Maine; Christy Olezeski, who is one of the psychologists at the Yale Pediatric Gender Clinic; excuse me, and Dee Farmer of Farmer v. Brennan, who -- we all coauthored this book chapter and the book chapter is written specifically for forensic psychologists who practice either -- you're either employed in a correctional setting like a prison or you provide services to folks in those settings. And so the book chapter is part of a -- a manual -- sorry, a textbook, I should say, about correctional mental health care. Ours is really -- so the entire book is not about transgender folks; it's a correctional textbook.

Q. Uh-huh.

A. Our chapter is the one that's about providing assessment and treatment to transgender folks who are in correctional settings. So we collaboratively wrote this chapter and it provides a little bit of background, but it mostly talks about ethical practice, areas of competency to develop, and, you know, considerations related to things like gender

testing norms and things like that.

So that's the book chapter. It is currently in sort of the final stages of -- I think we just sent in some of our last proofs, but I don't have the final, you know, PDF version of the chapter that will be published yet. However, my understanding is that they anticipate it will be published in September.

Q. Okay. And what's the name of the book that this is going to be in?

A. I do not remember the name of the actual book. I --

Q. Okay.

A. -- only remember our book chapter, which is, Incarcerated While Transgender.

Q. Okay. Was there a specific part of the chapter that you were responsible for drafting?

A. Yes. So I helped to write the parts about informed consent. I helped to write the parts about -- I primarily wrote the sections about informed consent. I don't want to make it sound like I entirely did it because we all edited each other's pieces. But I was

focused on the sections about informed consent, about cooccurring mental health conditions, and about -- a little bit about the minority stress issues in prison, and some of the testing and ethical considerations.

Q. Okay. Does the book chapter address evaluating transgender people with gender dysphoria for surgery?

A. Yes, as part of an interdisciplinary team.

Q. Okay. What does it say about that subject?

A. Well, so there's a lot that we say about it. So one of the things we talk about are the ethical issues with gatekeeping with the psychologist being the person who's in a role of saying this person should or should not have access to treatment. And so in our book chapter we take the position that that's not an appropriate role for a psychologist to take not because we believe other professionals are the ones who should be making that determination but because we believe that most trans folks are the experts on what they feel that would make them feel best as a -- as a starting point to that

process. So we did discuss that.

The testing part is really about, you know, that -- that's a challenging area so would probably be difficult to describe in brief, but about the importance of knowing the limitations of the current testing that we have available but also the utility of using testing and how we might offer caveats about it. So those are the sections that, you know, off the top of my head I recall I was primarily -- the primary author for.

Q. Okay. Does the book chapter address evaluating medical necessity for surgery?

A. Very briefly. Not in a lot of detail at all because none of us were medical doctors authoring the book chapter. Dr. Olezeski is part of an interdisciplinary team at the Yale Pediatric Gender Clinic and so in her -- in her group there's -- you know, there's her and then there's pediatrician endocrinologists so they collaboratively approach that and that was her input.

Q. Okay. And -- and what -- what is the input, if you remember?

A. Essentially, you know, that the -- the

medical aspects are best for the medical folks to make determinations about and have discussions with folks about but that the medical aspect of informed consent, for example, is not the only piece of informed consent that's important.

Q. Is there anything in the book chapter -- excuse me, book chapter about evaluating whether any treatment, including surgery, would be psychologically necessary?

A. I don't know that we used the word necessary so much as the word beneficial. So we did talk about that intervention is often beneficial for trans people. Obviously, it has to be tailored and individualized, but I think the fundamental, you know, gist of the chapter is that as psychologists, in fact, we should be advocates for trans folks receiving treatment that's appropriate for them, but part of that also means we're -- we're usually referring to kind of broader advocacy within our organizations, not advocating on behart of -- behalf of one particular individual just -- just because they're trans but, rather, saying we need to do a good job

with our institutional culture of teaching more about how to effectively treat and work with folks who are sexual and gender minority.

Q. So the chapter is focused exclusively on incarcerated people; is that right?

A. Well, yes. I think there may be readers who are involved in parole or probation kind of supervision, but that's not the primary audience for the book.

Q. Understood. So does -- in your view does the psychological evaluation of transgender people in a carceral setting -- is that different from the evaluation of -- of transgender people in a community setting?

A. Yes.

Q. How so?

A. Well, for one thing, there are a number of constraints that are present in the carceral setting and there's also a lot of points of possible intervention starting from sentencing before the person even enters that particular setting. There are a lot of ways in which the individual trans person doesn't have the kinds of choices in a carceral

setting that they would have in the community. That also includes access to social support where -- the way that most prisons are set up even geographically makes it very difficult for people to have contact with their family members. So there are aspects of the prison setting that are unique and there are ways in which our opportunities as psychologists are constrained as well compared to community-based treatment.

There are also differences, too, in that in the community, there isn't necessarily a right to medical treatment the way that there is in a prison. And so that is also a significantly different sort of configuration of how we might think about accessing mental health care. There are many, many people in the community who I'm sure wish they also had the right to access medical and mental health care, but the reality is that the way that when we're looking at practicing, the correctional setting is the one where people are supposed to get it.

Q. And what is your understanding of the -- the right to receive healthcare in prison?

A. My understanding of it is based on my forensic training so it's not a legal understanding; it's --
Q. Sure.
A. -- a forensic psychological understanding. But most of the time, what we talk about is the Estelle v. Gamble case and the idea that because people have been dep- -- if someone has been deprived of their liberty and they're in a carceral setting, then that is what creates the obligation to provide medical care to them.
Q. You talked about -- you used the term psychologically beneficial; is that right?
A. Right.
Q. Does -- can someone's carceral status affect whether any given treatment would be psychologically beneficial?
A. Yes.
Q. How so?
A. For example, with post-traumatic stress disorder, one of the things that a lot of people don't realize about post-traumatic stress disorder is that the first step in treating PTSD is achieving safety for the

person, not actual treatment or what most people would think of as treatment. In carceral settings it actually pays to be hypervigilant. It is important for your safety to monitor your environment for threats. Depending on the type of setting that you're in, other people may have incentives to mistreat you or try to gather information from you or something like that. So these are generally much higher-stress settings for most people compared to a community-based environment and certainly, that's one thing that -- I'm just giving PTSD as an example.

Another issue can be if you have a condition like schizophrenia. There are a lot of options for treatment in the community that are typically not available in the carceral setting for a variety of reasons. Some of the medications that people take require frequent blood work and -- to make sure they're not getting poisoned or that their, you know, white blood cell count isn't out of whack or something like that.

So there are treatments for medical --

or, sorry, psychological conditions that are -- we have to adapt or sometimes they're just completely unavailable in carceral settings for a variety of reasons.

Q. Does the unavailability of a treatment or intervention mean that it -- it -- it wouldn't be psychologically beneficial or does it just mean for -- like, for practical reasons, you can't do it?

MR. RODRIGUEZ: Objection to form. You can answer.

A. Do you mind re- -- repeating the question?

Q. Sure. So -- see if I can remember what I said. In -- so if you have a -- one of these treatments or interventions and if -- if it's not available, were -- did you mean to say that that treatment wouldn't have a psychological benefit for someone or simply it just isn't available for practical reasons?

A. So that's a good question and the PTSD is a pretty good example for that one. So they do have PTSD treatment in prisons including in the federal prison system. However, you know, as I said, the first step in PTSD

treatment is actually ensuring that the individual is safe. And so you can -- you can deliver interventions that might -- might benefit -- that same intervention might benefit that individual in the community if they were safe and if they didn't have the stressors associated with the carceral environment where the exact same individual and the exact same treatment produces a far greater benefit because of the fact that when they're in the carceral system, they have factors that are actually actively maintaining their illness because of the stress and the threat of the environment, even the social context of it. So even for the same individual, they might get a different benefit in the community versus a carceral setting with the exact same treatment.

Q. Is there any health condition you can think of where the -- the benefit to the patient would be maximized in a carceral set- -- excuse me, a carceral setting as opposed to a community setting?

A. I can't comment on medical conditions, but I

can say for mental health conditions --

Q. Uh-huh.

A. -- that's a difficult question because of the fact that there are some people who will only get care while they're incarcerated because of the fact that they're so poor and they're so limited in terms of their access in the community. I've certainly seen people where I -- I frankly had anxiety about their release because my concern was that they were going to get no care in the community. However, I can't think of a -- you know, offhand of a psychological condition where I would say that that's true.

Q. Okay. And so getting back to gender dysphoria, is there any gender-affirming treatment or intervention where a patient would not receive psychological benefit simply because they are incarcerated?

A. I don't think there's enough information for me to answer that question. Like, it's -- it would depend so much on the circumstance it's hard for me to come up with an example of one.

Q. Okay. Well, just -- I mean, the fact of

incarceration itself --

A. Uh-huh.

Q. Can the fact of incarceration itself mean that a treatment will have no psychological benefit to a patient?

MR. RODRIGUEZ: Object as speculation. You can answer.

A. I think there are situations where it would be less. I don't -- I'd have to -- I'm not sure if there would be a situation where I would say there would be none. I think it's possible that that would -- would be, but it would depend very much on the person's circumstances. So if they were in solitary confinement or double solitary, for example, and you're trying to give them a mental health treatment, it's -- you know, or -- or a treatment for something related to gender dysphoria but they're in double solitary with someone who's acutely transphobic, yeah, I could absolutely see that almost no matter what you did to help that person, unless you resolved that issue, they're going to continue to be acutely distressed.

Q. Okay. Anything -- we've gotten off track a

little bit. Anything about the book chapter that we haven't spoken about that you think is interesting or that you're proud of?

A. Well, one thing we are working on doing is making the book available to folks -- we want to make sure the book chapter is available to incarcerated folks themselves and not just the professionals. So one of the things that we are working on is making sure that not just the book is available in prison libraries for use by incarcerated people, but we're also working on a version of our chapter that will be available for folks who have significantly limited literacy so essentially like a multimedia presentation of the chapter content so that incarcerated tran- -- transgender folks themselves can access all the information in our chapter.

Q. I think that's great. Not a -- that's a comment, not a question.

All right. Changing gears a little bit, let's flip to your teaching and training experience. Sorry. Having trouble finding it.

A. Page 8.

Q. Thank you. There we go. Okay. So I want to ask you about the first item listed, Conducting forensic mental health evaluations with individuals who are transgender or gender nonconforming.

Did I read that right?

A. Yes.

Q. Okay. What -- is this a -- a training that you did?

A. Yes, through the University of Virginia.

Q. Okay. What did the training involve?

A. So there were multiple presenters. I'd have to re- -- I'd have to go back and look to see the names of everybody, but Dr. Olezeski was one of them who coauthored the book chapter and we had a panel discussion as well. And so the description in my CV is pretty accurate about, you know, what the considerations are for folks who are trans or gender nonconforming in -- we say criminal justice context, not correctional, because we are also talking about evaluations that might be conducted on folks who are in the community, not presently in custody. The ethical considerations, we were talking about

things like gatekeeping, about not dead naming and things like that that could be harmful to the person. Example language and queries for taking a gender development history, so that was basically how to query these things in a respectful way and really to some extent it was etiquette. The case law was covered by another presenter. And referral considerations, those were primarily, like, medical referral considerations. At that time, we were still under WPATH Standards of Care 7 where there were requirements for -- more requirements in terms of written letters and that sort of thing so we also addressed the -- that is what we're talking about when we're talking about referral considerations.

Q. You mentioned the -- the WPATH standards. What did you mean -- I think you said you were under the WPATH standards. What --

A. Oh, the -- yeah.

Q. What -- what --

A. The new ones had not been published yet so in terms of -- I have -- I don't endorse the WPATH standards, the 7 -- the Version 7.

That's why I'm not a member of WPATH and have not been historically. However, in terms of the actual practice that you see most psychologists having to engage in, if a transgender comes into your office and they say, I need a letter, usually what they mean is, I'm in the process of getting the -- you know, contacted an agency or an organization. They've indicated, I need this letter so I'm coming to you to get a letter.

And so most of the time, what's happening is that the people who are actually going to be providing the medical care to them are operating under the WPATH standards of care and require two letters then from medical professionals. And so we had to -- that -- you know, that was the understanding and that's what you comply with. Whether you agreed with that provision or not, you knew that their medical care providers were going to require that.

Q. Okay. So I know that you don't endorse WPATH. I'll get to that in a moment. Did you say that most providers en- -- endorse it or follow it? I can't remember exactly what

you said.

A. I would say that most of the medical care providers that I -- that I've worked with are utilizing those standards in terms of how they determine somebody's appropriateness and what kind of hoops they should have to jump through before they can have --

Q. Uh-huh.

A. -- what they want. I would say that's -- it's an -- like an informal organizing kind of set of expectations for us as psychologists is that that's -- what we're going to do is what WPATH suggests we do in terms of providing letters and the requirements his- -- the historical requirements that the person have socially transitioned for a period of time before they're allowed to have those interventions and so forth. And so it was mostly that we ex- -- we believed that -- that the medical professionals were going to expect that of us in order to agree to do the procedures for the person or prescribe medication.

Q. Okay. Are -- do you have, like, a wholesale rejection of the WPATH standards or are there

specific parts of it that you disagree with?

A. The newer version that just came out, I think there are significant improvements there. My primary concern with WPATH is that it's predicated on a -- what I view as a binary-oriented medical essentialist model and I don't think there's an -- that WPATH has created enough room for nonbinary people or people whose gender may be not -- people who may not necessarily need or want surgical procedures or hormonal intervention. I also think that most of this treatment has to be highly individualized for the person. And I think WPATH describes themselves as these are flexible guidelines, you know, not a -- set in stone. But that's -- yeah, that would be my response to that question.

Q. Okay. So when it comes to the WPATH standard for, let's say, evaluating someone for -- evaluating someone and referring them for hormone therapy, what do you think of what WPATH says?

A. I think that most folks are able to make that decision. You know, my issue with it was that I didn't believe that somebody should

have to have transitioned socially for a period of time before they're permitted to access hormonal intervention or surgery.

Q. Uh-huh.

A. That's really my primary issue with it. I also don't think they should have to have so many letters from psychologists probably.

Q. Okay.

A. And that was my historical objection to WPATH was really more about the ways in which I felt that they actually prevented trans and gender-nonconforming folks from receiving care rather than facilitating it because my view is WPATH has a -- like I said, a narrow medical essentialist model historically, although I do see an improvement in the eighth version of the standards of care.

Q. Okay. So summing up, do you -- you think the -- the seventh standards are too restrictive with respect to you referring someone for gender-affirming care?

A. Yes. I think there were a number of people that were probably held back from receiving care that they needed because those standards were excessively restrictive.

Q. Okay. All right. Back to your CV. I'm looking at the third item down in your teaching and training experience --

A. Yes.

Q. -- University of Virginia health services panelist: How experience might inform ethical practice, et -- et cetera.

What -- what did this involve?

A. This was a training that was set up by Janet Warren, who was our training director at the time. The original focus that she wanted to have was on girls in the criminal justice system, but we wanted to expand that model for basically gender minority folks as well. We ended up having a panel. It was myself, Christy Olezeski, and then I think it was Dallas -- I'm blanking on her last name. She's actually fairly well known. I just can't remember her last name for some reason, but she is a service provider. And so we were answering questions after folks had participated in a training on that topic. So I wasn't involved in the training that preceded that; I was involved in the -- just the panel so just answering questions from

the audience.

Q. Okay. Did this training have anything to do with evaluating gender dysphoric patients for gender-affirming care?

A. Yes. You know, like, for example, one of the questions that we got was, you know, does trauma cause somebody to be transgender? Is that something that needs to be resolved before somebody can get care? So those were the kinds of questions that the attendees had. It was that kind of -- it was just being available to answer questions. But I -- the questions that they asked were pretty revealing of what the issues were with the attendees --

Q. Uh-huh.

A. -- I think, too.

Q. Uh-huh. Was surgery addressed?

A. That actually did not come up much at that panel discussion, which is -- you know, we were focused on younger kids at that -- you know, adolescents at that time.

Q. Okay. Did any of the other entries under your teaching and training experience concern gender dysphoria?

A. I think on Page 11 there's the Migrant Network Coalition workshop coleader. So at this point in Lexington, they were considering some very restrictive anti-immigrant policies and we developed this workshop to talk about issues with folks who were sexual gender minority but also who had cooccurring disabilities and were potentially undocumented or -- or had other concerns about their immigration status and how aggressive anti-immigrant policies would actually cause those people to be more likely to be victims of crimes.

Q. Anything else?

A. Not -- I will tell you I do not recall if Project Safe, which was the project related to trying to promote excessive bil- -- disability accessibility from rape crisis and domestic violence agencies -- I don't recall if that included discussion of sexual and gender minority folks who are transgender or not.

Q. Okay. All right. Well, if that's everything there, let's turn to -- let's see -- your presentations. Once again, missed it. I

know it's in here somewhere.

A. Page 12.

Q. Thank you. All right. So in these presentations, did any of these concern transgender people or people with gender dysphoria?

A. Yes. In fact, one of them I'm very proud of.

Q. Which one is that?

A. Yes. So the second entry, Boyd, Barretto, and Zelle -- so this was myself, a psychologist who is a J.D./Ph.D. and who specializes in advanced directives for Virginia and then another -- a -- a transgender woman who had had some -- was, you know, openly disclosing that she had had some post-traumatic stress disorder. And so what we did was we created an advanced directive for her and the whole point -- we presented at the Philadelphia Trans Health Conference that year and the point of it was that, look, you can use an advanced directive as a transgender person to communicate with, like, for example, local hospitals about how you want to be treated if you're incapacitated. So if you get in a car

accident, you have a mental health episode, something happens and you go to the hospital, you can specify in advance, here's how I want my hormone therapy to be maintained, here's who I want to visit or who I do not want to be allowed to visit, here's how I feel about the use of restraints or seclusion techniques. You can use all of that and you can communicate in advance to help to protect your rights and to document what your -- you know, what your needs were in advance of, you know, God forbid, an incapacitation.

So we developed an example one for my copresenter and then we presented it at the conference to -- to demonstrate primarily for trans and gender-nonconforming folks about how they can utilize advanced directives to protect their rights in the event of incapacitation.

Q. Do you know if it's been used any time since for -- by other folks?

A. I do not know. I -- I know we developed one for -- you know, what we did partly was we talked about how to do it and then we presented the example one that we did --

Q. Uh-huh.
A. -- for my -- for my colleague. I'm -- I'm hoping that other people are using it and Dr. Zelle is still very much involved in advanced directive work and is, I believe, spreading the good word about it.
Q. Any of these other presentations, did they concern gender dysphoria or transgender people?
A. No.
Q. Okay. Then in that case, let's turn to your professional community service, which I'm sure you'll beat me to again. That's on Page 5.
A. Oh, you know -- all right. Yes.
Q. All right. In your professional community service, have -- have you had any particular focus?
A. It's primarily been related to, you know, as I mentioned earlier, my three primary areas, which is sexual/gender minority populations, intellectual and developmental disabilities, and interpersonal violence. So the diversity committee founding member thing is what we talked about before as a graduate student

representative and then the others relate to intellectual and developmental disabilities primarily.

Q. Okay. And in these activities do you ever perform mental health evaluations?

A. Oh, no. These -- no. These were, like, advisory panels --

Q. Okay.

A. -- basically.

Q. That being said, is there anything here that you're parti- -- particularly proud of or that you think is just important for understanding your career?

A. Well, it's more of a big picture thing, but --

Q. Uh-huh.

A. -- you know, one of the things that you probably see throughout this is that the disability aspect is quite a strong component of my training and I would say that disability is sort of -- that framework is the organizing set of principles around a lot of what I do.

So, for example, you'll notice there's no publications that I have or presentations

that I have about trans folks that don't involve a coauthor -- another coauthor who is also trans or gender nonconforming and that comes from -- in disability we talk about nothing about us without us and that is a, you know, important value that we have coming from that community, but I think it organizes a lot of my other work even when the focus is not specifically on disability status.

Q. Okay. All right. I'm going to change gears a little bit and hand you what we're calling Number 2. It's just your expert report in this case.

(BOYD EXHIBIT 2, Expert Report of Sara E. Boyd, Ph.D., ABPP, was marked for identification.)

BY MR. SIEGEL:

Q. All right. And I want to flip to the appendix, which is a list of cases.

A. Yes.

Q. And that's where -- these are cases that you provided --

A. Uh-huh.

Q. -- expert testimony in; is that right?

A. Yes.

Q. Over the last four years?
A. Yes.
Q. All right. So for the cases listed here, did any involve a person with gender dysphoria?
A. Let me take a look. None of these do. I believe the last case that I testified in that involved a transgender individual was a criminal case and I don't think it's on this list because it only covers the last four years.
Q. Okay. Do you remember the name of that case?
A. I believe the person's last name was Ernest.
Q. Okay.
A. They're deceased, unfortunately.
Q. Do you remember the jurisdiction it was in, the court?
A. It was in Virginia. I don't believe it was in one of the jurisdictions that I typically testify in so not northern Virginia. I'd have to go and look it up.
Q. Okay. Do you remember if it was State or Federal Court?
A. It was State Court. It was a sentencing.
Q. And what was your involvement in that case?
A. This was an individual who had been convicted

of sex offenses and was up for sentencing. She was a transgender woman who had a number of mental -- significant mental health problems. At the sentencing what I spoke about primarily was my concern about her well-being and safety in the carceral environment and why I believe that ought to be a mitigating factor in terms of her sentencing and what considerations they might undertake to keep her safe if she were to serve a custodial sentence. The court did not do what I suggested and she did ultimately die by suicide.

Q. Any other cases not listed here that involved a person with gender dysphoria or gender-affirming treatment?

A. Well, I currently have, I think, three cases right -- not counting this one, three cases right now that involve folks with gender dysphoria or who are transgender but not -- do not have gender dysphoria. I will say, though, that most of the -- in most of those cases, their gender identity is relevant but not the central question so those aren't cases where I've been asked to give any kind

of opinion about their, you know, informed consent for a procedure or something like that.

Q. Okay. In those cases has the court qualified you as an expert in any of them?

A. Yes.

Q. Okay.

A. So in the sentencing I do not recall -- the one that I just told you about, Ernest, I do not recall it -- how I was qualified specifically because it's usually either very narrow or very broad. I don't recall if I was qualified specifically as an expert in transgender and gender-nonconforming folks in that case or not. It would take me a minute to think through past testimony regarding other trans folks. I've never had to testify in a case -- it just hasn't occurred. They've always been resolved. -- involving a incarcerated person where I was evaluating them while they were incarcerated and then giving an opinion about, for example, informed consent-related issues.

Q. Okay. So in -- make sure I understand what you're telling me. The -- in the cases --

you have three cases pending --
A. Yes.
Q. -- that involve a transgender person or someone with gender dysphoria; is that right?
A. Well, they're either trans and they have gender dysphoria or they're trans and they don't have gender dysphoria.
Q. Okay. In any of those cases that -- that are pending --
A. Uh-huh.
Q. -- has the court qualified you as an expert?
A. Oh, no. We haven't -- we're not to the point of testifying in any of those.
Q. Okay.
A. And I haven't been appointed in any of them; I was retained by counsel.
Q. Okay. Can you give me the names of those cases?
A. I cannot because they're confidential mental health cases. I could probably try to ask the attorneys if I could disclose, but because my work is in progress and I don't even know if the other side has been notified that I've been retained, it would potentially be an issue for me to disclose that.

Q. Okay. Speaking generally without giving away any confidential or sensitive information, do those cases concern whether a person with gender dysphoria should or should not receive a certain treatment?

A. Yes. So -- but they're a little bit more nuanced than, you know, is it, like, gender-affirming treatment. It's usually a broader look at what is their -- what are their mental health needs generally speaking and what do they need and for a lot of those folks, that may or may not include a component of, you know, gender-affirming care.

Q. Okay.

MR. SIEGEL: All right. We've been going for about an hour. I think now is probably a decent time to take a short break --

MR. RODRIGUEZ: Yeah.

MR. SIEGEL: -- if that works for you all.

MR. RODRIGUEZ: Yeah.

(Whereupon, there was a recess in the proceedings from 9:59 a.m. to 10:14 a.m.)

BY MR. SIEGEL:

Q. Back on the record. All right. Dr. Boyd, welcome back. I just have a couple follow-up questions from what we were just talking about. Excuse me. I want to briefly revisit the book chapter.

A. Uh-huh.

Q. Does the chapter discuss how prison administrators or prison officials should weigh an individual's determination that they need a gender-affirming intervention in -- in deciding whether to give them that intervention?

MR. RODRIGUEZ: Objection to form. You can answer.

A. We don't discuss sort of the administrative decision-making in there, but we do note that that's a factor that's present in that kind of setting or administrative decision-making and requirements that may not be present in the community in terms of making a distinction between care in prison and care in the community.

Q. Okay. So there's nothing about how that individual's self-determination affects

treatment decisions?
A. We do talk about that in the informed consent discussion but not --
Q. Okay.
A. -- with respect to how administrative folks should take that into account.
Q. Okay. And this is maybe -- you may -- may have already addressed that, but how -- what do you say about that in the informed consent discussion?
A. I would have to have the chapter in front of me to able to refresh my recollection. I think it's more of a discussion about the idea of taking a problem-solving approach even internally as a psychologist.
Q. Okay. Earlier, you also mentioned that in your view, WPATH is too restrictive; is that correct?
A. Historically that it has been, yes.
Q. Okay. When you said it's historically too restrictive, is that also in reference for access to gender-affirming surgery?
A. The -- the issue with the restrictiveness is more about, like, a general concern that it's not a very culturally competent approach,

that there's assumptions that people have the ability, for example, to socially transition for a period of time before they can have those kinds of procedures done. So that's really more the critique --

Q. Okay.

A. -- whether it was hormones or surgery or some other intervention.

THE WITNESS: My apologies.

BY MR. SIEGEL:

Q. All right. And with respect to your expert testimony, you said that you had not had to testify about -- or testify in a case concerning someone with gender dysphoria; is that right?

A. I've testified in cases that involve folks who have gender dysphoria. I -- the question that I've testified about has usually not been whether or not they should have access to treatment specific to gender-affirming care. I have testified about access to mental health treatment more broadly for folks who happen to be trans, but the central question wasn't related to their gender identity.

Q. Okay. And so other than the cases that you have pending, in the cases where you didn't end up testifying, were you ever engaged to write an expert report concerning gender-affirming treatment?
A. Yes.
Q. Okay.
A. Yes. So typically, for the Department of Corrections, for example, we would always submit a report for that, but it's -- none of those cases have gone to a point of any kind of litigation where I've had to testify.
Q. Okay. Did you end up drafting a report in those cases?
A. I believe in all of the ones for DOC, I've always written a report.
Q. Okay. And did any of those cases where you drafted a report -- did they concern gender-affirming care?
A. Yes.
Q. Which ones?
A. For the -- I mean, all of the ones that I did for the Virginia Department of Corrections would have related to that, would have used an informed consent approach, but it -- I

wouldn't have given an opinion about the person should have this procedure or this treatment. I would talk about barriers to those things or problem-solving that might be done if there was an issue, but it wasn't the case that I would write a report that -- you know, where the recommendation was, they should have this medical treatment.

Q. Okay. Can you give an example of -- just walk me through one of those cases and how you got involved and what your process was and what your report looked like.

A. So the director of medical services is usually who makes the referral. They provide me with information and authorization to enter the facility. I meet with the individual. I go through an informed consent process with them to make sure they actually want to participate in it because even though the referral came from the facility, they're not obligated to participate in the evaluation. And then I would evaluate the individual, meeting with them us- -- at least once in person but often twice. I conducted testing if it was necessary and then I would

draft a report.

So I gave you the example earlier of the individual who their initial asks were just related to basic cosmetic items, but what my report ended up focusing on was just their need for accommodations where they want -- if they wanted to pursue, for example, endocrine treatment because of their limited literacy and cognitive ability. So that was more talking about how we kind of remediate that so that person can have treatment that they want if they ultimately decide to pursue that.

Q. Okay. And in the reports that you drafted, did any of them concern gender-affirming surgery?

A. I believe so, at least a couple of them, but it -- most of the people that I've gotten those referrals for have wanted lower-order kinds of intervention in terms of the risk profile. So it's usually been more of the kind of physical, you know, clothing, commissary items, or endocrine treatment as opposed to surgery, although some -- at lea- -- I think at least three individuals

did want surgery.

Q. Okay. Do you remember which cases those were?

A. Not off the top of my head. I don't recall the names, but they were not cases that I testified in. As I said, I just wrote reports.

Q. Uh-huh. And you were -- you were not engaged by a private plaintiff for that; you were appointed by the court; is that right?

A. Well, I was retained by the Virginia Department of Corrections as --

Q. Okay.

A. -- an independent outside evaluator.

Q. Okay. And in these reports you didn't provide a medical opinion --

A. Correct.

Q. -- right? Were you providing an opinion as to whether surgery would be psychologically beneficial?

A. I don't believe that for any of those folks I did offer that opinion because, as I said, even for the people who, I think, ultimately wanted that, they were far earlier in the process. They weren't asking for it yet.

Q. Uh-huh.
A. But they described a kind of process that they anticipated going through ultimately where surgery would be part of that picture for them.
Q. And what surgeries were at issue in those cases?
A. I -- it was, you know, what people call bottom half surgery for most of those folks. I don't recall anybody wanting to have -- who was specifically seeking breast augmentation or removal, you know, chest surgery. But, yeah, I think it was all bottom half surgery.
Q. Okay. Any -- did any of those deal with vulvoplasty or vaginoplasty?
A. Not vulvoplasty. That's less common than vaginoplasty, but one person is a trans man and I don't believe he was seeking bottom half surgery. The three people who were were all trans women.
Q. Okay. In any of those cases involving bottom half surgery, did you -- did you conclude that surgery would be psychologically beneficial?
MR. RODRIGUEZ: Asked and answered.

You can answer.

A. No. I didn't give a medical opinion about, you know, whether the -- well, I should differentiate. There's a medical opinion about whether or not the procedure itself will likely be physically/medically successful. The question of whether or not it would provide them with psychological relief, I believe I have offered the opinion that endocrine intervention -- the things that the person was asking for, that those things were likely to confer a psychological benefit. I don't recall evaluating anybody who was at the point of asking for surgery where I gave an opinion about that.

Q. Okay. All right. Let's turn then to your clinical experience and employment. First of all, is this -- is there any work in your career that you found particularly interesting and gratifying?

MR. RODRIGUEZ: Objection, vague. You can answer.

A. Yeah. That is a big question.

Q. In your clinical experience and employment.

A. I mean, as I said, you know, my primary areas

of focus have been developmental disabilities, interpersonal violence, and then sexual/gender minority populations. Those are the areas that -- the reason I focus on those are because those are the areas that I find more interesting and rewarding.

Q. Okay. So I'm looking at the first page of your expert report.

A. Yes.

Q. And I'm in the second sentence in the second paragraph.

A. Yes.

Q. You write, As a psychologist specializing in forensic mental health assessments, I have conducted more than 100 evaluations of incarcerated people housed in state and federal prisons and jails. In particular, I have conducted independent psychological evaluations related to gender-affirming care for incarcerated individuals.

Did I read all that correctly?

A. Yes.

Q. So how many evaluations related to gender-affirming care have you done?

A. Spe- -- where that was specifically the referral question, I think I would say somewhere around 20 --
Q. 20? Okay.
A. -- to 25.
Q. And --
A. I should -- oh, I should be clear, too. Those are folks that I know were transgender so it's certainly possible I've evaluated people who were trans that I just didn't know that they were.
MR. RODRIGUEZ: Speak up.
A. That I just didn't know that they were trans. Apologies.
Q. Okay. And -- and these 20 or so evaluations, you were evaluating them related to whether they needed gender-affirming care?
A. Yes.
Q. Okay. What does that mean?
A. In my report I describe that. So in that -- the sentence that says, In that ca- -- starts with, In that --
Q. Uh-huh.
A. -- capacity, so there's the capacity to provide informed consent part, which is

looking at do they have any conditions that would impair their ability to understand the information and make decisions.

To describe the nature and severity of their gender dysphoria if present. So that's typ- -- that was required by the Virginia DOC that the person have a diagnosis of gender dysphoria. So I would describe whether or not they met criteria and, if so, what symptoms they had.

To offer recommendations with respect to gender-affirming interventions or building capacity to provide informed consent. So, for example, you know, I would have no problem recommending that somebody receive access to boxers if that's what they want or something like that that's not a medical intervention. So those kinds of things I would often recommend. When I say, building capacity to provide informed consent, I gave an example of that earlier, the individual where I said, don't just give them a handout that they're supposed to read and understand. And then the last part says, Identify any cooccurring psychological disorders that may

require more active management or integration into treatment planning for gender-affirming interventions. So that's the detailed description of what I did.

Q. Okay. I'd like to focus on the part where you say part of your job is to offer recommendations with respect to gender-affirming interventions.

In any of these cases, did you offer recommendations with respect to gender-affirming surgery?

A. Not with regard to whether or not someone ought to have it or not but, again, making sure they understand. That -- that the information is delivered to them in a way that they can comprehend and understand would be more of my consideration in that regard.

Q. So I'm not -- I'm trying to under- -- so -- beg your pardon.

So you're not offering a recommendation in those cases that this patient needs or doesn't need some kind of gender-affirming surgery; is that right?

A. I would usually convey what the individual told me about what they wanted and needed --

Q. Okay.
A. -- rather than necessarily saying, you know, that I think they should have surgery.
Q. So then what kind of recommendations are you offering?
A. So if the -- if the person has, for example, other psychological disorders that are cooccurring with it, then I might offer recommendations about how -- if there's a relationship between those things and the gender dysphoria, for example, but it's not going to be treated -- the cooccurring condition is not going to be treated solely by gender-affirming intervention. We need to integrate those treatment recommendations together.

And so that would be -- it would be more of, like, a coordinating sort of -- there's an interdisciplinary approach to it where I address the issues that are appropriate for me to address as a psychologist but the medical folks are the ones who would say, you know, physically or medically this person can tolerate this or they understand the risks and the benefits of the medical aspects of

it. So my part was really only one piece of it. And then that was an independent evaluation that would go to the Virginia DOC and then their committee would take into account my evaluation, the physician recommendations, and then their in-house folks who had usually already done their own gender dysphoria-related evaluations that were just diagnostic prior to my engagement.

Q. Okay. So just to make sure I understand this, using the term psychologically beneficial, in any of these evaluations were you making a recommendation that gender-affirming surgery would be or would not be psychologically beneficial to the plaint- -- excuse me, to the patient?

A. I don't believe I have offered either of those opinions.

Q. Okay. When you were conducting these evaluations, were you using any clinical guidelines?

A. Well, so we have some -- as psychologists we have some guidelines. There were some that were published in 2008 and there were some that were published in 2015 by the American

Psychological Association task force. However, those are general guidelines for psychologists, not necessarily for forensic psychologists, and I think it's important to acknowledge the caveat that we don't have as much guidance in the forensic setting in the correctional setting. It's part of the reason -- it was part of the impetus behind the book chapter.

Q. Okay. You've shared your views on WPATH. Were you using or referring to the standards of care when you were conducting these evaluations?

A. Not in the correctional setting because the questions that are asked by Virginia DOC, they don't necessarily -- at the time at least, they hadn't necessarily deferred to WPATH so they had their own requirements, although, like I said, my -- mine was only really one piece of it. They had intern- -- an internal process with people and a panel, I believe, that I was not involved with.

Q. Okay. To clarify, what do you mean deferred to WPATH?

A. Well, you mean -- I'm sorry. You mean --

Q. You said at the time, the system didn't defer to WPATH.
A. They had their own administrative procedures --
Q. Okay. I see.
A. -- that didn't necessarily map onto what WPATH or -- or even reference WPATH at that time.
Q. Okay. Do you know if they do now?
A. I do not know.
Q. Is there anything else in your employment and clinical history that you think is important to understand as relevant to this case?
A. Not that I can think of.
Q. Okay. So in -- in light of what we've discussed, when it comes to evaluating patients with gender dysphoria for gender-affirming surgery, do you consider yourself to be an expert?

MR. RODRIGUEZ: Objection to form. You can answer.

A. I have expertise in that area. If I were qualified as an expert -- I would have no issue with that if I were qualified by a court. I don't consider myself to be

somebody who is promoting myself as an expert very broadly in that. I'm really focused specifically on the kinds of evaluations that I do. In the car- -- and it -- and it's broader than carceral settings, too, because it's other forensic settings outside of that. But I would say that, yes, I -- I am an expert in conducting evaluations related to gender development and psychological aspects of gender-affirming care.

So I think it -- you know, if there was an area where somebody was asked me to -- asked me to give an opinion related to expertise in that area and I felt I did not have that more narrow expertise within that area, I would choose not to answer that question.

Q. Okay. Do you consider yourself to be an expert in evaluating patients to determine whether gender-affirming surgery would have psychological benefit?

MR. RODRIGUEZ: Objection to form. You can answer.

A. Yes, I think I can give opinions about whether or not somebody would achieve a

psychological benefit.

Q. Okay. And so can you tell me where -- in your education, training, experience, et cetera, where specifically does that expertise come from?

A. So as a psychologist, I -- well, I should say clinical psychologist, I'm trained very broadly in what psychological interventions are likely to provide relief to indivi- -- individuals with various kinds of mental disorders. Now, within that field that doesn't mean that every psychologist is an expert in every disorder, but we do under- -- but we are trained in the process of evaluating and treating those conditions. When you're going to practice in a more narrow area like the forensic area or an even narrower area of forensic area with transgender folks, then you have a combination of treatment in -- or treatment -- training in graduate school. There's an experiential component of actually inter- -- you know, working with trans folks as opposed to simply reading about it in a book and then there's also the publications

that I've done and the trainings that I've created and co- -- cofacilitated.

I wouldn't say that that means that I could be -- that I would be the right expert for every case where that's the question. There could certainly be factors in play that would cause me to feel that I would not be the right expert or that I lack the appropriate expertise and in that case, I simply would not take the referral and I would do my best to make a tailored referral to somebody who I felt did have that expertise. So, for example, there could be a cultural minority group where I just don't know enough about that and even though the question relates to treatment in a carceral environment for a transgender person, I might still say, I'm not expert in this.

Q. Uh-huh. Anything else in your career, training, or experience that gives you expertise in evaluating a patient with gender dysphoria for gender-affirming surgery?

A. I don't recall if we've mentioned this yet, but I did do some psychotherapy with folks when I was still doing that with people who

were in the process of seeking gender-affirming treatment and most of those folks were still in the process of seeking kind of -- you know, for most people, they do endocrine treatment initially and most of those folks were at that phase. They were younger folks, you know, typically, like, late adolescents.

Q. And did the psychotherapy ever involve evaluation for surgery?

A. So I wrote letters for folks do- -- documenting that they had a diagnosis of gender dysphoria, that their other conditions were relatively well managed, that they had been socially transitioned for a period of time. I wrote those kinds of letters for folks to utilize to seek services.

Q. Okay. Does services mean -- sorry. What does services mean?

A. Yeah. So if they were going to go to get even endocrine management, they would typically want -- their -- their doc- -- their physician would often want a letter from someone like myself. So those folks could have approached me saying, I just want

the letter, can we do an evaluation, but typically, what they wanted was psychotherapy, supportive psychotherapy, through that -- throughout that process as well. So this is when I was still doing therapy.

Q. Uh-huh.

A. In recent years, I only do forensic evaluations so I don't do any of that anymore.

Q. Okay. And did the services that you're referring to ever include surgery?

A. Nobody that I was working with was at the point where surgery was the next step. For mo- -- for most of the ones that I recall, it was part of their plan, but they weren't at the point of that being the next step.

Q. Okay. And so just so I understand all of your answers, has there ever been a time in your career where you evaluated a patient with gender dysphoria and you made a recommendation that gender-affirming surgery either would or wouldn't confer a psychological benefit?

MR. RODRIGUEZ: Objection to form. You

can answer.

A. It's possible that I may have said that, you know, for somebody having a procedure that they would get a psychological benefit from it. I don't remember enough detail about it to provide you with more of an answer than that.

Q. Okay. And I want to go back to something you said a moment ago when you're writing letters.

A. Uh-huh.

Q. You said that -- I think you said that their other conditions had to be relatively well managed; is that right?

A. Right.

Q. What does that mean?

A. Well, historically, we -- you know, there's a little bit of vagueness in the language. That's from the WPATH Standards of Care 7. The idea was that if the person has cooccurring conditions like -- let's say if they have schizophrenia or something like that, that they need to be generally stabilized on their medication treatment regimen. Their symptoms need to not be

fluctuating too much or so out of control that they're, you know, frequently being hospitalized or something like that. That was the guidance from the standards of care at that time.

Q. Pausing to take a drink of water. Excuse me. Okay. Turning back to your report.

A. Uh-huh.

Q. Did you draft this report?

A. Yes.

Q. Okay. Did anyone else draft this report?

A. No one else has -- this is my writing.

Q. Okay. Oth- -- other than attorneys for the defendants, did anyone else participate in drafting this report?

A. Oh, no.

Q. Okay. Did you speak to anyone other than defendants' attorneys about drafting this report?

A. I believe I informed Kanautica that I would be drafting a report when I met with her, but she didn't see, like, a version of it beforehand or anything.

Q. Okay. Anyone else?

A. No.

Q. Not -- Dr. Joseph Penn?
A. No.
Q. Okay.
A. I've actually never spoken with Dr. Penn.
Q. Okay. Did you review documents in preparing this report?
A. Yes.
Q. What documents were those?
A. There were medical records which were cited to in the report. The earlier -- I think the earlier declaration may have provided more detail about the rec- -- the records that I reviewed, but there were numerous medical records that were provided to me. I also reviewed Ms. Zayre's -- Mrs. Zayre-Brown's deposition, the video, and there was a transcript that was provided to me as well.
Q. Okay. And I'll just point out it's -- it's pronounced Zayre.
A. Zayre?
Q. I even was mispronouncing it for a while. It's Zayre-Brown --
A. Okay.
Q. -- so for --
A. Thank you.

Q. Sure.
A. Oh, and I also read Dr. Ettner's submissions.
Q. Okay. Did you request any other documents for the purpose of preparing this report?
A. I don't believe so.
Q. All right. Did the attorneys for the defendants instruct you to make any assumptions in preparing this report?
A. Not that I recall. I mean, I should say there's a referral question, right, but that -- nobody asked me to make any assumptions about anything being true or not.
Q. All right. Was there any other information provided to you for the purpose of preparing this report?
A. So Dr. Ettner's testing was provided to me, most of the raw data for Beck Depression Inventory, Beck Anxiety Inventory, and the Trauma Symptom Inventory. And then obviously, there was the examination that I did including testing.
Q. And you said you'd never spoken to Dr. Penn. Have you spoken to Dr. Li about the report that she submitted in this case?
A. No.

Q. All right. So what opinions have you reached in this case?

A. So on Page 3 of my report there's a section called, Summaries of Opinion, and that's where I identify the four primary opinions and conclusions. The first opinion is essentially that in my view, there were deficiencies in Dr. Ettner's assessment; that secondly, I don't believe that a clinical psychologist can reasonably predict with confidence that a particular intervention will be curative of gender dysphoria; and that -- also, that my evaluation of Ms. Zayre-Brown -- Mrs. Zayre-Brown did not reveal significant find- -- findings from her current mental status that would counsel in favor of pushing the timing up so that it would be -- the procedure would be done while she's incarcerated based on her statements. And then the fourth aspect of my opinion was that based on the totality of information that I've reviewed, Mrs. Zayre-Brown's gender dysphoria is multifaceted and has multiple contributions aside from the fact -- aside from the contribution of not having had

the -- the vulvoplasty or vaginoplasty that she wants. So those are the four primary opinions that I offered.

Q. Okay. You say primary opinions. Are there other opinions in here?

A. Well, the -- you know, for example, when I say that the con- -- Dr. Ettner's process was undermined by deficiencies, there's, like, secondary, you know, critiques to that that are --

Q. Uh-huh.

A. -- covered under that umbrella is what I mean.

Q. Okay. All right. I'm going to flip to Page 33 and I'm looking at Conclusion Number (1)(a). You write, A psychologist who lacks formal medical education and training should not offer medical opinions, e.g., medical necessity, or state that their opinions are reliable and valid to a reasonable degree of medical certainty.

Did I read that right?

A. Yes.

Q. All right. What is your basis for this opinion?

A. Ethically, we're obligated not to offer opinions that are outside the bounds of our competence and our training. If you're not a medical provider, you shouldn't be giving a medical opinion. So, for example, if I'm testifying in court and someone asks me to give an opinion that's fundamentally a neurological opinion --

Q. Uh-huh.

A. -- or a -- a question about, well, if we gave this person this medicine, do you think it would make them feel better, I can't answer that question because I'm not a medical doctor and that's what I would say is, that's a medical question. You need a medical doctor to answer that. It's outside the bound of my com- -- bounds of my competence as a psychologist.

Q. Okay. And you said it -- it -- it's an ethical matter. Is there a -- you know, a published ethical code that you follow?

A. Yes. So there's APA ethics code and then there's -- they call them guidelines. They're all guidelines, but the -- there's a forensic specialty guideline ethics code as

well.

Q. Okay. So are -- are you providing an opinion in this case on medical necessity?

A. No.

Q. All right. In your view, can a psychologist like yourself or Dr. Ettner ethically provide an opinion on whether something is psychologically necessary or perhaps, as you put it, can provide a psychological benefit?

A. Yes.

Q. All right. I'd like to spend a little bit more time on that term. What does -- what does it mean for something to have a psychological benefit or to be psychologically beneficial?

A. Right. So --

MR. RODRIGUEZ: Objection.

A. -- typically, we're talking about treatment in this context, right, some kind of intervention that would be delivered to the person. So beneficial generally refers to either we're managing the person's symptoms so that they don't get worse or we're actually ameliorating the symptoms so that they improve, which might not mean that

they're cured and it might not even mean that they no longer meet diagnostic criteria for it, but they might have a significant relief in terms of the emotional pain that they're experiencing or cognitive limitations or behavioral problems that they're having. In some cases it can, you know, kind of at the extreme be essentially curative whereby the symptoms are ameliorated to the point that you fall below the diagnostic threshold. You may still have some persisting symptoms that are bothersome to you, but you no longer meet criteria. Occasionally, there are interventions that can be essentially curative, but for many psychological conditions, we often don't necessarily think of them as being cured but, rather, in remission because of the tendency that a lot of psychological conditions have to come back.

Q. Uh-huh. And so psychologically beneficial would encompass all of those things that you just mentioned; is that right?

A. Yes.

Q. Okay.

A. But it's still important to make the distinction because we don't want to assume that because something is psychologically beneficial that that also makes it curative.

Q. Okay. And I think you told me what curative means a moment ago, but can you tell me again what -- what does it mean to be curative?

A. Well, curative is not a technical term.

Q. Uh-huh.

A. But essentially, what we mean is that there's either a condition where the person's symptoms drop below the level that's required -- the threshold that's required for a diagnosis, right. We use this Diagnostic and Statistical Manual. It has criteria that you have to satisfy in order to have a -- meet criteria to have a certain condition. You know, let's say that you have to have four of those criteria. With significant, you know, benefit from psychological treatment, you may drop down to only having two of them. You still have those two things. They might be bothersome to you, but because you don't have four, you don't qualify for the disorder anymore. So I would

not consider that curative; I would still consider that to be an amelioration. Curative would be you have no symptoms of the condition.

Q. Understood. So is there a difference between a treatment being psychologically beneficial and medically necessary or medically beneficial, whatever the correct term is?

MR. RODRIGUEZ: Objection, medical opinion, but you can answer.

A. Yeah. There is a difference and that's why I don't -- that's why I can give an opinion about benefit without giving a medical opinion. So, you know, if somebody asked me, you know, if this person has electroshock therapy, will their depression be cured, I wouldn't be able to give an opinion about that. What I could give an opinion about is, here's what seems to be contributing to their depression. Here's what parts of it appear to be biological or sort of mechanical issues with their brain.

Q. Uh-huh.

A. But here are the other things that may not be. And so here's why we have reason to

believe that the person may need more than ECT.

Q. Okay. When it comes to gender-affirming surgery, in your view, can that ever be -- or could it ever be psychologically beneficial but not medically necessary?

MR. RODRIGUEZ: Objection, medical opinion. You can answer.

A. So saying something's not medically necessary would be giving an opinion about medical necessity so I would not give that opinion. What I would endeavor to do instead would -- to be very clear about for psychological benefit, you know, what does that mean, when, how, who, what.

Q. Uh-huh.

A. What are the circumstances where the person is most likely to achieve the best psychological benefit that they can get. I wouldn't give an opinion about, you know, this surgical technique versus that surgical technique or this medication versus that medication.

Q. In your experience, in your training, are you aware of any patient who was seeking

gender-affirming surgery and their providers determined that, yes, it's psychologically -- it would be psychologically beneficial, but, no, it wouldn't be medically necessary?

A. I'm not typically privy to how the internal committees within the Virginia -- for example, Virginia DOC make those kind of determinations so I don't usually even know what necessarily happens in terms of the endpoint of those cases. So I'm not sure what kind of determination was made by those kinds of panels.

Q. Okay. So in your view, who would be qualified to make a determination on medical necessity for gender-affirming surgery?

MR. RODRIGUEZ: Objection, medical opinion, outside the scope of this expert's opinions. You can answer.

A. So if some were to -- someone were to ask me for a referral for that, I would say it would need to be a medical professional, but the type of medical professional could depend largely on the individual person, what their needs were and what they were asking for. So a lot of times, an interdisciplinary approach

is a pretty helpful one for that where you've got a couple of different kinds of medical doctors so you might have an endocrinologist as well as a surgeon and a psychiatrist, for example.

Q. And do you have a sense of how a medical provider would go about determining whether surgery's medically necessary?

MR. RODRIGUEZ: Objection, medical opinion, speculation. You can answer.

A. I don't feel enough -- I don't feel that I know enough to say whether or not I know enough about that. I'm not -- I'm not familiar enough with the decision-making processes that they utilize for medical necessity to be able to give an opinion about that.

Q. Okay. Are you familiar at all?

A. I've certainly read depositions where physicians were discussing medical necessity. The -- I don't think that I'm an expert on medical necessity. I wouldn't give an opinion about medical necessity.

Q. Okay. Let's flip to Page 5 of your report.

A. Uh-huh.

Q. So I am in the second paragraph, last sentence, and you write, I know other psychologists like Dr. Ettner and I who also perform similar evaluations related to gender-affirming care for transgender and gender-nonconforming individuals and, in my experience, it would not be typical for them to offer medical opinions.

Did I get that all right?

A. Yes.

Q. All right. Who were the other psychologists you're referring to?

A. So one would be Dr. Olezeski and her colleagues at the Yale clinic. These are the -- some of the folks that I was thinking of in particular because they conduct a lot of trainings. The last one they did was for the APA last year and although they don't offer medical opinions, they work collaboratively with medical doctors so they're not completely siloed off.

Q. Uh-huh. Anyone other than Dr. Olezeski, if I'm pronouncing that correctly?

A. Yes, you are pronouncing that correctly. So Sarah Miller, my coauthor. I don't believe

Dr. Campbell has offered those opinions, who's also my coauthor on that chapter.

Q. What is Dr. Campbell's first name?

A. Walter.

Q. Okay. So you say it's not typical for them to offer medical opinions. Do they ever offer medical opinions?

A. I can't say that I know enough about all of those individuals and everything they've ever said or did to be able to say they have never offered an opinion that I would not consider to be a medical opinion. So I can't -- I don't think I have the foundation and knowledge to answer that, but my understanding in my interaction with those folks is that they would -- their ethical principle would be not to offer one because it's outside the scope of their competence --

Q. Uh-huh.

A. -- and I've never known them to do that.

Q. Okay. So for this assertion in your report -- excuse me, your report concerning offering medical opinions when you're a psychologist, are you relying on anything beyond your personal professional experience?

A. Well, so we have authoritative texts that provide guidance on these topics. We -- there's a -- Mental Health Evaluations for the Courts by Melton and colleagues is sort of one of our foremost texts that we would cite to that talks specifically about the importance of maintaining -- staying within the bounds of your competency as a psychologist. This is reiterated in our ethics code broadly, in our forensic guidelines more narrowly. Additionally, you'll see this in virtually any discussion of forensic psychological practice because it's not just that we shouldn't give medical opinions -- that's one pitfall, one kind of potential land mine for us.

Q. Uh-huh.

A. -- but also that we ought not offer legal opinions. That's the other area where we're significantly cautioned is not to offer legal opinions unless we are -- you know, like I said, I have colleagues who are J.D./Ph.D.s. that they might, but if you're just a psychologist, you would not. So it's not specific just to medicine.

Q. Okay. And these authoritative texts, do they say specifically something along the lines of, you know, forensic psychologists cannot, should not make recommendations concerning medical necessity?

A. I don't have a specific recollection that that -- the exact language regarding medical necessity. I would have to look at the text and see if that's an accurate representation of what they say.

Q. Yeah. Well, I mean, I don't expect you to remember offhand exactly what it says.

A. Uh-huh.

Q. Do you recall that it says something like that?

A. No.

Q. Okay.

A. I don't have a recollection.

Q. Okay. So can a psychologist, in your view, refer a patient -- can a psychologist refer a patient seeking gender-affirming surgery to a medical provider?

A. Yes.

Q. Okay. That's permitted by WPATH standards?

A. Well, in fact, WPATH talks about an

interdisciplinary approach at times. But an interdisciplinary approach could come because somebody goes to a clinic and the clinic takes an interdisciplinary approach or they could come to an individual psychologist or other mental health care provider or even their doctor and that person could refer them for intervention.

Q. Okay. So in terms of just what a -- a patient's care looks like --

A. Uh-huh.

Q. -- in your view, it's appropriate for a psychologist to conduct an evaluation, say, I think this treatment, surgery, or whatever would have psychological benefit, and I'm going to refer you along to a surgeon, endocrinologist, whoever?

A. Right. You -- I mean, you would also typically discuss whether or not a diagnosis of gender dysphoria is present or absent.

Q. Okay. All right. So still on Page 5. Bear with me just one moment. All right. I'm sorry. So this is second paragraph and it's four lines down. Thus, my role in such cases is not to make determinations regarding

whether a person should or should not receive a given intervention.

Did I read that correctly?

A. Yes.

Q. All right. And then let's flip to Page 2. And you say that part of your role is to offer recommendations with respect to gender-affirming interventions; is that right?

A. Right.

MR. RODRIGUEZ: Can you --

MR. SIEGEL: I'm sorry.

MR. RODRIGUEZ: Where are you -- yeah, where are you reading?

MR. SIEGEL: I'm sorry. Where is it? I don't have it highlighted on my copy.

BY MR. SIEGEL:

Q. Sorry. Bear with me just one moment, y'all.

MS. MAFFETORE: It's the first line --

MR. SIEGEL: Okay.

MS. MAFFETORE: -- on the second page, to offer recommendations with respect to --

MR. SIEGEL: Okay. Thank you.

MS. MAFFETORE: -- gender-affirming --

BY MR. SIEGEL:

Q. All right. So it's -- yeah. It's the very first line after the comma, Part of your role is to offer recommendations with respect to gender-affirming interventions or building capacity to provide informed consent.
A. Uh-huh.
Q. All right. So did those statements that I just read, the one on Page 2 and the one on Page 5 -- is there any contradiction between those statements?
A. I think part of the difficulty that we're having here is that we're maybe confusing making recommendations with respect to gender-affirming interventions with recommending specific gender-affirming interventions.
Q. Okay.
A. So what I don't do is I don't say, this person needs to have this surgery or this person should not have this surgery. I don't --
Q. Uh-huh.
A. -- say either one of those things.
Q. Okay.
A. But what I might say is, you know, what this

person has articulated is that they would like to -- you know, for example, I might say, I think they should be provided with information about what their options would be for bottom half surgery because what they've described in terms of their ultimate goal might necessitate that based on how they've described the presentation that they want. So I might recommend, for example, like, they should be provided with more information about that and here's how they should be provided with that information. I might say, they would learn best -- if they're a bright person who likes to read, maybe give them a book. If they're not or they have literacy problems, I might make recommendations that are different. So it's not that I'm recommending what interventions they should have, but I'm providing recommendations related to gender-affirming interventions without saying that they should or should not have them.

Q. And so in this case, you -- are you providing an opinion whether Mrs. Zayre-Brown should or should not receive a certain treatment?

A. I haven't given an opinion about whether or not she should -- from my perspective she should or should not receive a given treatment, but what I have done and can do is describe what she has said she wants.

Q. Okay.

MR. SIEGEL: Let's take a short break, if that's all right with y'all.

MR. RODRIGUEZ: Yeah.

(Whereupon, there was a recess in the proceedings from 11:00 a.m. to 11:09 a.m.)

BY MR. SIEGEL:

Q. Welcome back, Dr. Boyd.

A. Uh-huh.

Q. All right. Changing gears somewhat. Are you familiar with the Division Transgender Accommodations Review Committee or DTARC?

A. I am familiar with their existence. I'm familiar with them to the extent that their activities were documented in the records that I reviewed, but I don't have independent knowledge of them outside of the information I reviewed in this case.

Q. Okay. So based on what you reviewed, excuse me, what is the DTARC?

A. It's a committee that I believe reviews requests and then provides approvals for various stages of the process. So there are administrative processes for approving evaluations, scheduling consultations, and then approving procedures.

Q. Do you know who's on it?

A. No.

Q. Are you familiar with their decision last year to deny Mrs. Zayre-Brown's request for gender-affirming surgery?

A. Yes.

Q. Do you have an understanding of how DTARC reached that decision?

A. No. My primary focus was about how Mrs. Zayre- -- Zayre-Brown received the news and responded to it --

Q. Okay.

A. -- more than the deliberation.

Q. Okay. I'm going to hand you another exhibit. I think this is Exhibit Number 3 that we're on.

(BOYD EXHIBIT 3, Division Transgender Accommodation Review Committee (TARC) Report, 2/17/2022, was marked for identification.)

BY MR. SIEGEL:

Q. Dr. Boyd, have you seen this document before?

A. This actually may have been included in the records that I reviewed. This front page does not look fam- -- as familiar, but the -- the second and third page does.

Q. Okay.

A. Although it's possible that it looks familiar because it was cut and pasted from another section of the records. That often happens.

Q. Okay. So take another moment to review if you'd like --

A. Sure.

Q. -- and then just let me know what this document is --

A. I will tell --

Q. -- or appears to be.

A. Yes. So this appears to be a report that documents a determination that was made by the -- the Division Transgender Accommodation Review Committee. So it documents what information they reviewed. It provides a brief narrative and a medical analysis is the latter portion. It details who was in attendance at the time of the meeting and on

the front -- on the cover sheet there's an indication that the purpose of the review was related to gender-affirmation surgery/vulvoplasty and the accommodations referred for final determination includes the decision that says, DTARC does not recommend gender-affirmation surgery stating, This surgery is not medically necessary.

Q. Okay. I think that sums it up. Are you familiar at all with the professional background of the -- the individual defendants in this case?

A. No. Be- -- not beyond what their title is as reflected in records.

Q. Okay. Do you -- do you know if any of them have medical training?

A. I believe some do. I believe your -- that, for example, your chief medical officer is a physician.

Q. All right. Any of the others to your knowledge?

A. My -- well, typically, the chief of psychiatry would be a psychiatrist, who's also a medical doctor, so it's likely that person is also a physician.

Q. Okay. So based on this document, the DTARC recommended that gender-affirming surgery was not medically necessary, correct?

A. That's what the form states, yes.

Q. Okay. So if any of the members of the DTARC who participated in this recommendation did not have medical training, would that have been appropriate in your view?

MR. RODRIGUEZ: Objection to form. You can answer.

A. So that's a -- this is a good example of why the interdisciplinary approach is important. So you can see there's a medical analysis section that -- there's a heading specific to that. I would suggest that someone without a medical degree should not be involved in the decision-making regarding, like, the deter- -- the actual determination as far as saying this is medically necessary or not. However, it may benefit the folks who have the background to men- -- make the medical determination to have the input from folks who have a background in mental health and/or who are administrative folks who know more about what the internal regulations and

requirements are so they can have input and they may provide information that the folks who make the medical determination find relevant and necessary. But as far as who signs off on the medical analysis and who drafts it, in my opinion, that should be a physician -- it should be someone with a medical degree.

Q. Understood. Okay. You can set this aside if you'd like. So a lot of your report is talking about informed consent and you've spoken about that some today. I'll just ask a very basic question of what is informed consent and why does it matter?

A. Right. So informed consent, broadly speaking, refers to the necessity for individuals who are participating in treatment or evaluation to knowledgeably agree to participate or receive that treatment or evaluation. So that's, like, in the very broadest sense. And informed consents in our practice as psychologists means that people are knowingly participating in -- whether it's an evaluation or treatment, that they are a -- given the

opportunity to be provided with the information that they need to understand the risks and the benefits, the costs, and, you know, have a reasonable and reality-based appraisal of that before they are asked to make a decision. There's two parts to it. One is making sure they have the information. The other part is the autonomy of the individual to choose to participate or not.

Informed consent in terms of providing care to folks who are transgender has -- is slightly different. So we still have the core informed consent obligations that we're required to maintain ethically in terms of our practice, doing evaluations or -- or doing treatment, but informed consent is also, somewhat confusingly, the name of a different kind of approach to assessing individuals and providing treatment to individuals who are transgender, whether they're in the community or a carceral setting. It's not specific to a setting. And what it means is that instead of saying that our role is to decide if somebody is trans or not, instead, our role is to make

sure that the person not only has the capacity, right -- which capacity doesn't mean you already have all the information; it just means you have the ability to understand and process that information, make decisions. Not only do they have the capacity, but have they been provided with the information that they need? Are they in a position to make a decision about it and do they have the support that they need to do that? So an informed consent approach to conducting these evaluations is different even though it uses the same terminology as informed consent in terms of an ethical obligation on the part of psychologists when they're conducting activities involving patients, clients, or research participants.

Q. Okay. So when you are evaluating patients for informed consent meaning, I think -- well, let -- I'll let you answer that. When you're evaluating a patient for informed consent, which one of those do you mean --

A. Right.

Q. -- and how do you do it?

A. Right. Well, unfortunately, another

complicated answer.

Q. Okay. Great.

A. So one version of looking at this could be, like, a Miran- -- a competency to waive Miranda evaluation, which is retrospective and it's looking at whether or not the person knowingly, intelligently, and voluntarily waived their rights to a custodial interrogation so you might look at their capacity. Do they have an intellectual disability, do they have a severe psychiatric problem, were they under severe stress, things like that. So that's one area where it's -- you know, that's one area where it's different.

But informed consent in this process refers more to positioning the individual who's seeking treatment in such a way that they can access the support that they need, have the information that they need delivered in -- to them in a way that they understand so that they can make a decision collaboratively with their treating professionals about what treatment they need, when they should get it, how it should be

delivered.

Q. In this case did you assess Mrs. Zayre-Brown's ability to provide informed consent?

A. I used an informed consent approach and part of that was assessing her capacity to provide informed consent and I did ultimately come to an opinion regarding that.

Q. Okay. How did you go about making that assessment?

A. I looked for the presence of any conditions that could potentially interfere with her capacity to provide informed consent and then I just asked her direct questions to ascertain her fund of knowledge and her beliefs about different kinds of scenarios and options.

Q. Okay. Could you be a bit more specific on --

A. Certainly.

Q. -- how you did that.

A. Yes. So in reviewing her records, for example, I looked for conditions that could be expected to potentially, even just in a time-limited way, impair her capacity to provide informed consent. So I looked at

mood issues, cognitive issues. Those are the -- those issues and psychosis are the most common kind of barriers to that.

After you see whether or not those things are present, if they are present, then you look to see, are they relevant? In other words, are they active now when the person -- or during the relevant time period when you're looking at the decision-making, which for Mrs. Zay- -- Zayre-Brown is now.

So she does have some cooccurring conditions. You know, in my view, though, at the time that I saw her, those symptoms were not so active or impairing that they would impair her capacity to understand what her options are and make decisions.

Q. Okay. Does that mean you concluded that she can provide informed consent?

A. I believe she has the capacity to provide informed consent in that, you know, narrow -- more narrow kind of ethical obligation of ensuring that she's not, for example, agreeing to a procedure when -- in a -- without a reality-based understanding.

Q. Okay. If you could flip to Page 31 of your

report. And this is beginning of Section E. Sorry. I'll wait till -- for you get there.

A. Yes.

Q. Oh, I'm sorry. It's actually the -- the first full paragraph on the page, which reads, Mrs. Zayre-Brown's expectancies for the surgical aftercare that would be available to her in prison were less realistic in light of history.

What does that mean?

A. So this interview was -- was video recorded.

Q. Uh-huh.

A. And this is a reference in part to the discussion that Mrs. Zayre-Brown and I had about her experience when she initially entered custody and had had surgery about a month before that -- be- -- before her sentencing. And so she was still recovering from a surgical procedure and that's where the -- part of where that relevant conversation started. We discussed what care she had already received and that's why I say in light of the history. When I say that her expectancies for surgical aftercare that would be available to her in prison were less

realistic, I say that because what she was describing in terms of what she expected to receive in terms of aftercare was a radical departure from what -- the care she described actually receiving.

Q. Okay. And the care that she described receiving with respect to recovering from the orchiectomy --

A. Yes.

Q. -- in 2017; is that correct?

A. Yes.

Q. All right. Was there a -- anything else in your assessment that contributed to your statement here that her views were less realistic about aftercare?

A. So here we're talking about surgical aftercare specifically --

Q. Uh-huh.

A. -- so not other elements of aftercare. And, yeah, so that particular statement is related to that discussion.

Q. Okay. And so my question is, was there any other statement that she made or any other part of your assessment that contributed to that observation you made?

A. The result of her formal testing by me --
Q. Uh-huh.
A. -- indicate that she has a personality style where she is -- she has a tendency to, like, idealize situations sometimes that are prospectively positive so that can cause her to be a little bit like a cork on the ocean where a good thing happens or something seems like it's going to be really promising and relieving and her mood goes up significantly. At the same time, when she gets news that something is not going to happen, her mood can drop down really dramatically. And in my view, that affects her ability -- when she's in those states, that does affect her ability to accurately appraise and anticipate what's going to happen in the future, but that could happen in either direction depending on the circumstance. I think this is an example of her idealizing what would be available to her. And I say idealizing it because she is com- -- I'm comparing it to what she has told me about her own experiences prior to that.
Q. Uh-huh.
A. And she was not able to provide me with

information that was -- would indicate that there were -- there was an evidence base for believing that the circumstances that she described as ideal for her and most likely to give her relief and benefit would actually happen in a prison setting.

Q. And what would be ideal?

A. So she articulated it herself and I describe it on that same page, the last paragraph before Section E. Her idea -- her view of an ideal surgery context would include, A, receiving medical care in the community, including aftercare and wound care management; B, the opportunity to receive care and support from her husband, friends, and family; and, C, participating in meaningful personal and professional development opportunities while she is preparing for surgery and recovering from surgery.

So this is her statement about what she sees as an ideal surgery context. Now, when I say she idealized things, I'm -- here that's not what I'm talking about. This is her -- just her self-report, her description

of what she thinks would be optimal for her --

Q. Okay.

A. -- clinically. What she described as far as what -- how she thought recovery -- what recovery from this procedure could look like in a prison setting, she described having more access to physicians, more regular care than she described having at the time that she initially entered prison in 2017.

Q. Got it. Do you have an understanding of what postsurgical care is like for a vulvoplasty?

A. I have some familiarity, but I can't give a medical opinion.

Q. Okay. I'm not a asking for a medical opinion, just to your knowledge. Is -- is it anything more complicated than basic wound care?

A. It depends on the individual. The vulvoplasty differs from vaginoplasty in that most individuals, you know, there wouldn't be a reason to use dilators, for example, but depending on how the procedure is done, how skillfully it's done, what the individual's history is -- she did have complications

through her wound care before from the orchiectomy but -- you know, it can be complicated for individuals, but it -- you know, it depends on the person. All I can rely on for her -- from her is what she tells me about what her prior experiences were with her ability to manage wound care. And I think it is fair to say that it's certainly a risk, probably a more significant risk for vaginoplasty compared to vulvoplasty, but both of them would carry risks and a physician would have to be the person -- a surgeon would have to be the person to give you an opinion.

Q. Okay. So other -- other than her experience in 2017, do you have any other reason to be concerned about the quality of aftercare provided in the state prison system?

A. I'm re- -- again, I'm relying on her report.

Q. Okay.

A. I'm relying on what she has personally experienced and the aftercare that's available in one facility or for one individual could be different even within the same prison system.

Q. Speaking very generally, do you have concerns about the quality of care offered in the prison setting versus the community setting?
A. With respect to mental health care, which is really what I'm able to comment on, yes.
Q. Okay. Could you tell me why.
A. Prisons are inherently stressful environments. Restrictive housing in particular is a highly stressful environment. It's well documented that it's incredibly psychologically stressful.
Q. Uh-huh.
A. The analogy I sometimes give is that depending on where you're at in the prison is the psychological equivalent of getting hit in the head -- or getting -- yeah, getting hit in the head with a hammer every day and wondering why your skull isn't recovering. You know, you could get medical treatment --
Q. Uh-huh.
A. -- you could get stitches, but if you're still getting hit in the head with a hammer every day, you're not going to get a lot better. And that's part- -- partly an issue of confinement. It's partly an issue of who

you're around, what your population is and -- and who your social community and your peer group is and whether they're dangerous to you or not. But from a mental health perspective it is -- you know, we would most -- I don't know any psychologist who would say that it's not a -- a psychologically stressful environment.

Q. Uh-huh.

A. So there's that aspect to it. Doesn't mean the community can't also be stressful. Being unhoused --

Q. Uh-huh.

A. -- for example -- you know, there are all kinds of ways that the community can also be stressful, but just as a baseline, it's a more stressful environment. Sometimes people have access to services in there that they don't have access to in the community, but overall just as a baseline, it's a different environment from a psychological perspective.

Q. Okay. So I'm going to give you a hypothetical. In your view, assuming that a treatment would be psychologically beneficial for a patient and is medically ne- -- excuse

me, medically necessary, would the quality of aftercare available be a valid reason to deny that treatment?

MR. RODRIGUEZ: Objection to form, medical opinion. You can answer.

A. Denying the treatment would be an administrative decision. It's not -- and that's not a process that I'm part of. I also think that the individual's perspective on whether they feel they could tolerate, you know, those circumstances would be something to take into account. It's difficult to answer that hypothetical just because it is somewhat broad.

Q. Okay. Well, I'll narrow it a little bit. So you can also assume that this person has requested the surgery and has been seeking it for years. And I'm not talking about really the administrative decision. I'm talking about a decision by the healthcare providers treating the patient. So assuming all of that -- so we've got patient who wants a treatment. Assume that it's psychologically beneficial. Assume that it's medically necessary. Patient has been advocating for

herself for years.

In that case, would the quality of aftercare available be a valid reason to deny the treatment?

MR. RODRIGUEZ: Objection, medical opinion, legal opinion, speculation, form. You can answer.

A. I wouldn't say -- I wouldn't say that exactly, but I would direct you to, actually, Ettner's second declaration, Paragraph 38 where she describes a Cornell study regarding outcomes for transgender folks after they've had procedures done and one of the things that predicts outcomes is the quality of the surgical procedure and, I believe also, the aftercare that's available to that individual. That does affect the outcomes that people have.

Now, you know, there's critique -- there's different ways to talk about that and think about that. Regret rates are also related to the fundamental effectiveness of the surgical procedure and whether or not the person ends up with the outcome that they want. Now, as I'm sure you know, regret

rates are very, very low, but even within that group, one of the things that does predict it is if you don't get the surgical outcome that you want physically.

Q. All right. So getting back to Kanautica and informed consent --

A. Uh-huh.

Q. -- were there any aspects of informed consent that you assessed and haven't mentioned yet today?

A. Yes. I discuss in my report -- and forgive me one second. I want to locate it, the section. Okay. On Page 10 in the section that has a header that starts with, Dr. Ettner discounts the importance of a psychologist's role in informed consent, the second full paragraph, A prospective patient's understanding of the likely outcomes of a procedure and the timing of these outcomes is key to their ability to make decisions while also weighing the risks and costs. Skipping down a little bit to the second-to-last sentence, for example, a patient who believes an intervention will be curative may accept more serious or higher

probability risks compared to a patient who believes that an intervention will alleviate but not cure their symptoms. Communicating to a prospective patient, continuing on to the next page, Page 11, that a surgical procedure will be curative carries significant risk of misleading the individual and influencing their decision-making with inaccurate information leading to exaggerated proc- -- expectancies.

And so here what I'm speaking about, and I continue to talk about in the report, is the narrative -- is the information essentially that Dr. Ettner provided to Mrs. Zayre-Brown saying, this will cure your gender dysphoria. That is something that I did get into and I discussed with Mrs. Zayre-Brown because of my concern that if doctors are -- authority figures are coming in and telling her, this will cure your gender dysphoria, and that's not true or at least we can't say it with that degree of confidence that that's definitely what's going to happen, then that person may decide to undertake procedures under riskier

circumstances, less optimal circumstances that are likely to produce less benefit because they think, this is what's going to fix the pain that I'm experiencing. And so I do certainly have that concern and I discuss it in my report with respect to informed consent, wanting to ensure that Mrs. Zayre-Brown has accurate, reality-based information so that -- so that she can make her own decision.

Q. Are you expressing an opinion in this case as to whether Mrs. Zayre-Brown has actually provided informed consent for gender-affirming surgery?

A. I gave the opinion that I don't believe her capacity to provide informed consent was significantly compromised at the time of my evaluation of her so her capacity to provide informed consent to most surgical procedures at this point, I think, is probably intact.

I mentioned the information that I think has been provided to her that is misleading and I -- you know, obviously, I want to make sure she knows that that is my perspective so she has that information, too, in making her

decision, but the critique of Dr. Ettner is more related to, like, her approach, not giving Mrs. Zayre-Brown accurate information, not exploring no- -- as thoroughly I think as should have been done what her reasoning was and what her options were, really, all of her options, what is going to be best for her. And so that was my critique of -- of Ettner and the concern that I had with respect to informed consent.

Q. Okay. And so I'm -- I'm just trying to bet- -- to understand exactly what you're saying and what you're not saying.

A. Uh-huh.

Q. So Kanautica saw Dr. Figler at UNC, right?

A. Yes.

Q. And saw some other healthcare providers, right?

A. Yes.

Q. So are you expressing an opinion in this case as to whether she actually provided informed consent to any of those providers?

A. Oh, that's -- okay. So that's a good question. I think it's -- when I saw her, I did not see barriers to her having the

capacity to perform -- to provide informed consent to that kind of circumstance. The information that was provided in the records regarding what Dr. Figler actually told Ms. Zayre-Brown is very limited so it's hard to ascertain whether or not she was actually provided with enough information.

At the same time, there is a distinction between the informed consent process for surgery, which I believe she does have the capacity -- like, I think she does understand the risks and the benefits just purely from the medical perspective.

Q. Uh-huh.

A. The informed consent issue for me primarily relates to her psychologi- -- her expectancies regarding the psychological benefit that she will receive provided those surgical procedure -- procedures are effective.

Q. Okay. All right. Well, let's get back to Dr. Ettner so let's flip to Page 3 of your report. So this is summary of opinions. Second sentence, First, the opinions and conclusions of Dr. Ettner are undermined by

multiple deficiencies in Dr. Ettner's assessment, including the failure to apply an informed consent approach.

A. Uh-huh.

Q. So some of this will be slightly repetitive, but what -- what do you mean here by informed consent approach?

A. Right. So -- and this is a useful point of clarification. I'm not making the assertion that Dr. Ettner did not seek informed consent from Mrs. Zayre-Brown to participate in the psychological evaluation, but I do not know if she did or she did not because it's not documented. The failure to apply an informed consent approach here refers to the approach that Dr. Ettner took to the evaluation by not giving -- in my view not giving Mrs. Zayre-Brown accurate information regarding what her expectancies would be -- you know, should be for these procedures. There's very little discussion of that. That's what I'm referring to in that particular clause.

Q. Okay. So when you're talking about the informed consent approach, you make a

comparison -- I'm sorry. I don't have the exact page number -- but between what the WPATH says about informed consent and a different approach; is that right?

A. So I -- I know this is tedious because it -- it is nuanced, but --

Q. Uh-huh.

A. -- there's informed consent for the surgery. Do I know what they're going to do? Do I know what my alternatives are? Do I know the risks, the cost, the prospective benefits, and the relative likelihoods of those things, right? So that's one issue.

Another issue is informed consent as an approach to conducting these kinds of evaluations related to somebody's access to gender-affirming care, their capacity to provide informed consent. That's actually described in the new version of the standards --

Q. Uh-huh.

A. -- the eighth version. They describe an informed consent approach and that's what I'm talking about is the informed consent approach that's actually described in the new

version of the standards. That's not what I'm seeing in terms of Dr. Ettner's approach.

Q. Uh-huh. All right. So does that, what's in the new standards, require the involvement of a mental health professional in order for a patient to get gender-affirming care?

A. You mean in the informed consent model?

Q. Yes.

A. I actually -- I think it would probably not be responsible for me to answer that question without rereviewing that section. It's not a terribly lengthy section of the standards, but I -- I wouldn't want to inadvertently misspeak.

Q. Okay. Do you know if there are any hospitals or clinics that provide gender-affirming care that follow this -- the informed consent model?

A. Yes. So, for example, that -- the Yale clinic --

Q. Uh-huh.

A. -- my coauthor and I -- Dr. Olezeski, we discussed that in detail. The other coauthors, I believe, utilize elements of that in their approach, but because

they're -- I'm not referring to Ms. Farmer; I'm referring to Drs. Miller and Campbell. They are functioning within systems where they're constrained because the -- it's their employer --

Q. Uh-huh.

A. -- whereas, I'm typically acting as basically a contractor so I can do the evaluation in the way that I feel is most appropriate. I'm not -- they can utilize it however they want to use -- utilize it within their policies and procedures, but I'm not constrained in the same way that somebody who's actually employed in the prison by the prison is in terms of their practices.

So I use an informed consent approach. The community-based clinics, some of them including the Yale clinic do. With my other colleagues on the book chapter in particular, I believe they utilize it, but they have to defer to other kinds of requirements in terms of giving opinions that would be outside of, you know, what I might sometimes see as appropriate.

Q. Okay. So do you believe that

gender-affirming care should be provided to patients without the involvement of a mental health professional?

A. I think there are certainly people who could absolutely have gender-affirming care without the involvement of a mental health professional. If they want to have boxers, I don't understand why you need to talk to a psychologist about that, frankly. You know, that doesn't make any sense to me, but they -- they do. These are procedural kind of --

Q. Uh-huh.

A. These are regulatory and internal administrative processes. So as a matter of actual practice, yes, it is often the case that we have to be involved. As a matter of clinical utility, do we need to be involved all the time? No, probably not.

Q. And -- and so what about for surgery?

A. I think it would depend on the individual, but for most people, yes, you would have a psychologist involved at least in terms of an initial consultation and I would always suggest that a psychologist be made available

to the person to ask questions and also to check this particular aspect of informed consent because in my experience, surgeons do not typically get into the person's expectancies, their social and psychological expectancies, postsurgery and that is an important part of decision-making. If I have a surgeon or a team of folks who are knowledgeable about that and do undertake that practice regularly, I think it probably could be done by somebody who's not a mental health professional, but generally speaking, in practice, I don't see them doing much of that.

Q. All right. So you applied several tests or inventories in your assessment of Kanautica, right?

A. Yes. Well, I don't -- I wouldn't say several. It was two.

Q. Two. Okay. So let's start with the Trauma Symptom Inventory.

A. Okay.

Q. I'm sorry. Were you about to say something?

A. It's not mine. So I describe it be- -- I didn't -- I didn't administer the Trauma

Symptom Inventory.

Q. Okay.

A. I didn't administer the Beck Depression Inventory or the Beck Anxiety Inventory.

Q. Uh-huh.

A. Dr. Ettner administered those things.

Q. Uh-huh. Okay.

A. However, because she did not provide the results or even name what tests they were, in her documents, once I obtained those, I integrated them into my report because they do contain useful information and it is something also that -- Mrs. Zayre-Brown should know the results of the testing. So --

Q. You're right. I'm --

A. -- to be clear, it wasn't my test administration.

Q. Right. That was my mistake. I'm sorry for the confusion. I'd still like to talk about these, though --

A. Sure.

Q. -- and start with the Trauma Symptom Inventory.

What is it?

A. The Trauma Symptom Inventory is a self-report inventory. I believe it's 136 items and it is aimed at assessing current trauma symptomology so it's within the last six months. So it's not going to tell us what somebody's trauma symptoms were ten years ago. It's not going to tell us what their trauma symptoms are going to be in two years. It's a snapshot of how they've been doing recently.

The measure was developed using adults so it's not appropriate for children, but there are versions for children. It is widely used in the forensic context. It's certainly appropriate for this kind of case and it includes validity scales that tell us not just what the person reported but how they approached the test.

Q. All right. And did you review the results of this?

A. Yes.

Q. And what were the results?

A. So the results are described beginning on Page 18 continuing onto Page 19 and concluding at the top of Page 20. The

findings of this particular administration -- her -- the first thing to say is that her validity scale results were within normal limits meaning that there weren't indications that she's either significantly, like, really strongly denying symptoms that she likely has or that's -- she's exaggerating symptoms either to feign or malinger or as a cry for help. So it doesn't mean that everything in -- that she reported is true or accurate, but we don't have good reason to think that those kinds of factors, significant denial or exaggeration, are reflected in her results.

She had one clinical scale elevation and -- it's also important to be clear. When we say clinical, what we actually mean is statistical. So it's just an unusually high elevation compared to the samples of people who are used to develop the test. She had a clinical elevation on the defensive avoidance scale. Defensive avoidance is when a person who's been traumatized undertakes to avoid internal recollections of the stressful events.

Q. Uh-huh.

A. They don't like thinking about it. They don't like remembering it. But also external avoidance so it might be avoiding talking about their trauma. It might be saying, you know, if I'm going to do this psychological evaluation, I absolutely do not want trauma to be part of that discussion, which is what happened. It's very common because for most of us, if something terrible happens to us, we'd rather not dwell on it, right. So she has an elevation on that.

Her -- she had other scores that would be high but weren't statistically unusually high according to the demarcation that the test developers use. So she had -- her post-traumatic stress factor, which is the one that's intended to indicate how closely the person's presentation adhered to the diagnostic criteria for PTSD -- what's the likelihood they have PTSD now? So her score was high but not significantly elevated. So she sort of -- there's a little bit of ambiguity about it. Certainly, she has trauma symptoms, but do they cross the threshold into being diagnosable now is a

little bit of a question mark and would need to be explored with more testing to get a definitive answer. She -- but she was at the 82nd percentile meaning 82 percent of the other adults in the samples that were used to develop this test had lower scores than that so it's -- it is high.

Suicidality was similarly -- like, it wasn't -- it didn't cross a threshold into being statistically elevated, but it's certainly at a level of, you know, probably causing discomfort for her so that's 78th percentile.

When we look at the results, there are subscales for the suicidality that showed that she's not reporting suicidal behaviors like attempts or what we call parasuicidal conduct, but she was reporting that she think -- has thoughts about it at times.

As I stated in here, the score suggests she has some degree of trauma-related psychological symptomology which may have been below threshold for formal diagnosis and that her results suggested that she had not made suicide attempts or engaged in

parasuicidal behavior, which is, like, usually cutting, things like that, in the six months prior to the -- to Dr. Ettner's May 2022 TSI-2 administration.

Q. Do -- so do these results in any way indicate that gender-affirming surgery would be appropriate or inappropriate for Kanautica?

A. No. They're primarily relevant for figuring out if there's potentially other contributors to her distress aside from that and it also helps us identify kind of what are the prominent bothersome features of it for her presently so more just kind of her overall well-being. It does suggest to me that she probably would benefit from her treatment being trauma informed, that there needs to be a sensitivity to that, but it doesn't tell us -- it does not enable us to make a prediction about whether or not having surgery would change these scores.

Q. Okay. Anything else about the TSI that you think is important to note for Kanautica?

A. No, I don't believe so.

Q. Okay. Then let's move on to the Beck Anxiety and Depression Inventories. What are these

tests?

A. These are very brief tests. They don't take very long. When I was still doing therapy, if I had somebody who had depression or anxiety, they might get -- they might fill one of these out a week for me so they're quick. They are well-regarded tests. They have good psychometric data, but they're also closely correlated. Anxiety and depression are kind of like peas in a pod and it's always been hard for psychologists to really extricate those things. But they're not really deep dives. They are good for getting just a brief snapshot of where somebody's symptoms are, which symptoms are more or less pronounced. And on both of these, the scores that she obtained were not in the normal range. They were elevated, but it was mild elevation.

Q. Okay. And so same questions with TSI. Do these results in any way indicate that gender-affirming surgery would be appropriate or inappropriate for Kanautica?

A. They could relate to not whether or not the care would be appropriate but what kind of

support she might need as she moved through that process. But scores at this level aren't indicative of particularly acute distress and the acute distress could be relevant to either something that you might anticipate an intervention might alleviate or it might be relevant to understanding if somebody might have a temper or a limitation in their capacity to provide informed consent. If they're extremely depressed, for example, they may have trouble thinking clearly and reasoning and that kind of thing. So that's what they could be relevant to, but these results don't suggest that.

Q. Okay. So I'm looking at the beginning of the second paragraph in Part B and you say, Given these findings, it appears that trauma-related symptoms are a likely contribute- -- excuse me, likely contributory to her suicidality.

Did I read that right eventually?

A. Yes.

Q. Okay. Can you -- so what is -- what is the basis for this?

A. Well, so her presentation during my interview

with her, the -- even the correspondence about not wanting to talk about the trauma, that's -- you know, nobody really wants to, but that kind -- that was significant avoidance even before we met. And I can understand wanting to protect your rights and not wanting to say more than you have to say about your personal history, but to me, it's also indicative to some degree of avoidance.

And then, you know, she also has these episodes in 2019, 2020, and, I believe, also 2021 where she's had really acute distress and had to have kind of crisis care-type intervention. And in my view, it's likely that her trauma history relates to that because it's extremely common for people to have those kinds of issues when they have a significant trauma history especially if it was repeated and it occurred in childhood and it involved a disruption with their rela- -- with their caregivers. My understanding is that she was in foster care for a significant amount of time as an adolescent.

Q. How do you make a distinction between trauma-related symptoms and gender dysphoria

symptoms?

A. That's a good question and I do get asked --

Q. Thank you. I try.

A. I do get asked this, actually, a fair amount. Like I said, I get asked, doesn't trauma cause somebody to become trans somehow? And the fact is, no. The issue is that transgender folks are at significantly increased risk of any number of situations that are likely to result in experiencing traumatic stress or events and then subsequently developing a condition like PTSD. So very high rates of victimization of all kinds, exploitation, high rates of under- and unemployment, high rates of being unhoused, getting kicked out of your house when you're a child because your family rejects you. These are things that are not inherent to being trans. There's nothing about being trans that makes those things okay or natural, but they happen at a disproportionate rate to trans folks and they do cause traumatic stress and injury to them just the same way that they would cause traumatic stress or injury to other people,

but they just have an increased risk of encountering those kinds of circumstances.

And so it is something that commonly cooccurs. In Ms. -- in Mrs. Zayre-Brown's case she acknowledged that she had a history of significant trauma. In my view, it's not like it's fully explanatory. I -- what I'm not saying is, oh, this is all trauma, the gender dysphoria doesn't have anything to do with this. But what I'm saying is that in terms of significant relief from the -- the suicidality and the distress that she is experiencing, treating the gender dysphoria is really only one piece of the puzzle. There are other things that she's going to need in terms of support and care in order to get significant alleviation of those symptoms.

Q. Okay. Anything else about the Beck Inventories that you think are important to know?

A. Not that I can think of.

Q. Okay. Then let's move on to the Minnesota Multiphasic Personality Inventory, second edition. And you -- you did administer this

test --

A. Yes.

Q. -- correct? Okay. Great. I'll call it the MMPI --

A. Yes.

Q. -- for brevity sake. What is the MMPI?

A. The MMPI is one of our oldest and most widely used psychological inventories. It's broad, it's comprehensive, well researched, commonly used in the forensic setting, has correctional and forensic norms. It's probably the most commonly used psychological test, period, aside from maybe IQ tests if we looked at community as well. It is lengthy, but the 2-RF is called the restructured form. It's actually slightly shorter so I -- I use that to make it less painful and tedious because the full-length version is 567 items. The measure covers a broad range of psychopathology so it covers identity. It covers -- excuse me, like -- I should say self-concept, not identity, interpersonal functioning. It covers be- -- behaviors, mood issues, anxiety issues, somatic issues. I mean, it's got -- it's very, very broad

coverage for this measure and it was constructed differently than other psychological tests. It's harder to trick the MMPI or study the MMPI compared to other measures. It -- the nice thing about the MMPI-2-RF, too, is that when you're looking at testing -- doing psychological testing with trans folks, it can be really difficult because of the fact that if somebody is nonbinary, they don't necessarily fit into either of the gender norm groups and the tests that were used to develop some of these measures, they didn't ask people if they were trans or not and so we don't necessarily know if they have different results or the test might work differently for them.

So the reason I chose the MMPI is because it doesn't -- 2-RF does not use gender norms, which is, to my way of thinking, the best solution and also consistent with the guidance that we see in the literature on this topic.

Like the TSI, the MMPI contains embedded validity scales that tell us how the person approached the measure. Those validity

scales are not all created equal. Some of them work better than others, but her validity scale results were within normal limits, again, consistent with the Trauma Symptom Inventory that she wasn't faking or exaggerating things or -- or engaging in a significant amount of what we call faking good, which is pretending to be more virtuous and problem free than you really are.

As far as her results go, they're detailed in my report on Page 24. I provide T-scores there, but, you know, we're looking at scores -- 65 or greater, again, statistically significant. You could have a score that's lower than that that's still very bothersome to you. It doesn't mean it's not important if it's below that score. But she had some -- she had several elevations on this scale -- or on this measure, I should say, including externalizing dysfunction, cynicism, antisocial behavior, ideas of persecution, aberrant experiences, hypomanic activation. She had some mild elevation on a scale that reflected suicidality, high -- high stress and worry and specific fears.

So with the MMPI we don't just talk about individual scale results. We -- we integrate them and we talk about how these things would work together and present in an individual. And so for people who have this combination of results, I provide a narrative that starts at the bottom of Page 24, continues on to Page 25, and ends before the discussion about the Personality Inventory that starts at the bottom of Page 25. So I discuss a little bit more about the suicidality and the relationship between impulsivity and suicidality for her that -- I also just provide a little bit of context that it's not uncommon for incarcerated individuals to have elevated risk factors for suicidality and experience more of that.

The narrative part of it is, you know -- individuals who have this combination of results tend to describe a lot of frequent, intense, and ruminative worry. They preo- -- preoccupy themselves worrying about things. They're vulnerable to stress, which means -- I talked about her being like a cork on the ocean, that, like, when stress happens, your

mood can drop very quickly and dramatically more so than a typical person.

She has also some indications of hypomania which could mean bipolar. I did not diagnose that. I do think she deserves to know that that did come up on the testing and it's something that she should be mindful about, but it wasn't present to such a degree and she didn't present during the interview with me in a way that would cause me to think she was psychotic or something like that at that time.

She had some persecutory ideation. That doesn't sound good, but it's actually pretty normal in a carceral setting. You're worried that people are out to get you. You're probably not wrong. Also, I contextualized that finding given the circumstance of her litigation. The remainder of the findings are described in detail in the report and I don't want to belabor it since you have the report.

Q. Sure. Okay. So let me back up a little bit.

A. Uh-huh.

Q. And I'd like -- I'm curious to know more

about the -- the test itself.
A. Uh-huh.
Q. So I could probably parse this out from your last answer, but what does this test measure?
A. A very broad variety of what we call psychopathology.
Q. Okay. And what is psychopathology?
A. Things that can go wrong with your mental health.
Q. Okay. And why did you have Kanautica specifically take it?
MR. RODRIGUEZ: Asked and answered, but you can answer.
A. Well, the instruments -- the tests that Dr. Ettner had done were not, you know, these kind of more comprehensive, sort of omnibus almost style instrument. They were more narrowly focused and, you know, as I actually heard in one of your questions, like, not all that relevant really in some respects ultimately given the findings.
The MMPI doesn't tell us if somebody is trans or not. It doesn't even tell us if they have gender dysphoria or not. It's not a diagnostic instrument for that. It look --

it's more -- the aim of this is more to look at cooccurring conditions that the person might have and also what their strengths and challenges are in terms of personality and their interpersonal functioning because that can be relevant for treatment planning and capacity to provide informed consent.

Q. Do you know who created the test?

A. Yes. So it was created at -- well, it was -- it was a couple of different people.

Q. Uh-huh.

A. Ben-Porath is the person who publishes the most now about the MMPI, but it was created at a hospital in Minnesota. Many, many, many people completed earlier versions of the measure and, like I said, it was created very differently from a lot of other psychological tests but in, I think, a good way. It's called an atheoretical test development.

Q. Do you know if the test was created for a specific purpose?

A. Well, originally, I'm not sure if they were thinking of using it internally, but, I mean, it was developed as a psychological test for fairly broad use. Now, they have updated the

instrument over time. They've expanded the norms to be more representative of the population, but it's not appropriate for everybody. There are -- there are limits to it. The reading level, for example, can be too high for some individuals so it's not a test that is for everybody. I certainly don't want to make it seem like everybody should have an MMPI no matter what they come in for, that they're all suitable for it. But it was commonly used in the forensic setting not only because it gives you such broad coverage but also because it includes these validity scales and in forensic settings, you want to be able to offer some amount of, you know, I investigated whether or not this person was providing a forthright or accurate report with the information that I have. Measures like the MMPI permit you to do that.

Q. Okay. And so is this a diagnostic tool?

A. It's a diagnostic tool, but you can't rely on it solely for the purpose of diagnosis.

Q. Okay. Is it also used for assessing a patient's need for a specific treatment?

A. It could be. So, for example, if someone elevated on the depression scale and that was very, very high elevation and they elevate on -- you know, they produce a pattern of results consistent, for example, with borderline personality disorder, that tells us probably this person should have dialectical behavior therapy. Does the test output say, dialectical behavior therapy? No. But it does tell you what the picture is of their symptoms and then you can identify the best fit in terms of treatment after that.

Q. Okay. Did you have Kanautica take the MMPI for the purpose of assessing her need for a treatment?

A. So not so much for her need for the treatment but to get a -- an updated picture of what her current symptoms are, the severity of those symptoms, and then to be able to ascertain how that might interface with the likely benefit that she would receive from gender-affirming care, under what circumstances, and also if there was any need for active management of cooccurring

conditions that could interfere with either her ability to provide informed consent or her ability to benefit in the longer term from the procedure.

Q. Have you used this test with any other patients to assess a need for gender-affirming care?

A. Oh, I've given -- yeah, I've given MMPIs as part of that process, but it's not a situation where the MMPI gives me an answer as far as, A, whether or not the person needs gender-affirming care at all and it also doesn't tell me if they do, what it -- what specifically procedure or interventionwise that they need and that's a big universe. You know, it can be everything from voice training to your underwear to surgery. It's a spectrum.

Q. Uh-huh.

MR. SIEGEL: Okay. Can we go off the record for a moment?

(Discussion off the record.)

(Whereupon, there was a lunch recess in the proceedings from 12:06 p.m. to 12:44 p.m.)

BY MR. SIEGEL:

Q. All right. Back on the record. Dr. Boyd, welcome back. Hope you were able to get something to eat. Before we move on to the next subject, one follow-up question.

A. Sure.

Q. I believe you said that you had -- there might be some concerns about complications resulting from vulvoplasty.

A. Uh-huh.

Q. Do you have a sense of how common complications are from that procedure?

A. I don't know. What I would typically suggest is -- well, first of all, I would say that's for a -- the medical provider to talk about for Mrs. Zay- -- Zayre-Brown. Given her history, her collection of symptoms, her presentation, what would be most helpful would be to have an individualized prediction about that.

Q. Okay.

A. And probably contingent on setting, too. So give one opinion about risks in carceral environment and another one in the community.

Q. Okay. Got it. All right. Then looking back

to your report, I'm looking at Page 24.

A. Yes.

Q. And looking at the last sentence in the second paragraph you write, In other words, gender dysphoria is not necessarily the primary and direct cause of Mrs. Zayre-Brown's suicidality and urgent surgical treatment for her gender dysphoria will not necessarily reduce or eliminate her risk of having suicidal ideation in the future.

Did I get all that right?

A. Yes.

Q. Okay. Are you providing an opinion that something other than gender dysphoria is the primary and direct cause of her suicidality?

A. No. I would say there are multiple contributors and I don't think one could be identified as the primary cause.

Q. Okay. And what are the other contributors in your view?

A. So certainly, one is the -- the carceral status. You know, people who are incarcerated have roughly ten times the rate of completed suicide regardless of their

gen- -- actually, cisgender women have a slightly higher rate of completed suicide, ten times the rate of the general population. So the carceral status is one variable there.

Another one is, excuse me, that she does have -- she does have trauma symptoms and I do think those are contributing, but I also would not say that if you treated -- if -- if she is released from prison and she treats her trauma symptoms that that means the suicidality would go away. I don't think -- I think she needs intervention for all of the contributors.

Q. Okay. So you think that her gender dysphoria is a contributor to her suicidality; is that right?

A. Yes.

Q. Okay. And you're -- but you're not saying to -- you know, that's, like, 20 percent or 50 percent or whatever, are you?

A. I don't think it's possible to extricate it and provide a -- an opinion that would be that precise. So, you know, it could be 5 percent. You know, I -- I don't think it's possible -- I think it would be misleading to

offer a number.

Q. Uh-huh. Okay. So since -- since that is a -- a contributor in your view, if Mrs. Zayre-Brown were to undergo surgery, would that at least reduce her risk -- or would that reduce her levels of suicidality?

A. I think it depends. It depends on what -- how it's performed, under what conditions with what amount of social support. And that's consistent, again, with -- going back to the -- the declar- -- summary of the findings from the Cornell study. I mean, that's consistent with what is also demonstrated in that research literature.

Q. Okay. If it is performed in a carceral setting, do you believe that would reduce her suicidality?

A. I think that if she -- I think that her finding out that she has a date when she knows that she will be able to get her surgery done -- I think that will improve her suicidality whether she's incarcerated or in the community. So I think there's different kind -- and then getting the procedure itself will offer a different -- will have

additional benefit. I think at each step of the way -- depending on where she's located, each movement toward that process will likely offer her a psychological benefit both broadly speaking in terms of her mood because, like I said, she's like a cork on the ocean so good news will also lift her mood --

Q. Uh-huh.

A. -- but also, at the same time, it's not a solution. It's not going to make it go away and there are other things that could make her suicide risk fluctuate acutely. Even if somehow we could wave a magic wand and the gender dysphoria went away completely, that would still be a concern and would need active management.

Q. Okay. You mentioned additional benefits. What would those be?

A. I'm sorry. Do -- can you remind me --

Q. I -- I -- I think you said that if she were to undergo surgery, aside from suicidality there would be additional benefits. If that's not what you said or meant, please correct me, but that's what I heard.

A. Oh, well -- so, I mean, gender dy- -- dysphoria, it can -- it can be associated with suicidality, but it's associated with other things, too. And when I say benefits, I actually also mean, like, positive things, not just relief of negative experiences.

So, for example, she indicated that one of -- the -- some of the things she'd like to do involve sports and, like, dancing, things like that that she feels she can't -- in her deposition she talked about this a fair amount, that there are things she feels she cannot do because she hasn't had that bottom half surgery yet. That -- those benefits are significantly more relevant and accessible to her in a community than they're going to be in a carceral setting based on her own reasoning and her -- and her own statements about that. So that's what I mean when I say it could be different.

Q. Got it. All right. I'd like to turn to Page 34, please. And this is Conclusion Number 2, A clinical psychologist cannot reasonably predict with confidence that a particular intervention will be curative of a condition

such as gender dysphoria, which has a diverse manifestation and is inextricably bound up in aspects of the person's life and circumstances that go far beyond the physical appearance of their genitals.

Did I read that right?

A. Yes.

Q. All right. So big picture question. Like, can gender dysphoria be cured?

A. I think there are certainly people who could get to the point that they would be subthreshold, right. That's an -- I -- I've talked before about how there's difference between subthreshold and having no symptoms. I think certainly for most people, there's the possibility of bringing somebody subthreshold for gender dysphoria, but it's usually not the case that there's a single intervention that's sort of like a magic bullet. It's usually a combination of things that deal with, you know, as I allude to here, not just what their genitals look like or their secondary sex characteristics but also what their social environment is, what their supports are --

Q. Uh-huh.
A. -- what their access to care -- all kinds of care is.
Q. Okay. So why is it that a -- a psychologist can't predict that a certain intervention will be curative of gender dysphoria?
A. Because of the fact that it -- there's so -- there's other contributing causes. I mean, like, really just what I said there. It's not just about the -- the appearance of somebody's physical body. There are other factors there. So it's more like I'm saying there's not one thing most of the time. And for her specifically -- getting into her specifics, she articulates repeatedly that there are other factors that contribute significantly to her gender dysphoria, specifically transphobia that she encounters from other people and also to some degree, I think, internalized transphobia when she feels that she's been recognized and identified and then treated differently because she's a trans woman.
Q. In your view, can a psychologist predict with confidence that a certain intervention

wouldn't be curative but that -- but that it's necessary to achieving a cure?

MR. RODRIGUEZ: Objection to form. You can answer it.

A. We would call that necessary but not sufficient --

Q. Uh-huh.

A. -- in -- in our terminology. So it's a piece of it, but it's not going to get you all the way there is the idea. That's one way of looking at that, yeah.

Q. Okay. Would that be true for any clinical psychologist?

A. I'm sorry. I -- can you ask that question in a different way?

Q. Would it be true for any clinical psychologist --

A. That --

Q. -- that you cannot predict that a certain intervention will be curative?

A. I think it depends on the intervention and it depends on the individual.

Q. Okay. Well, how -- how about yourself, would that apply to you?

A. Well, yes. I mean, I think it would depend.

If I have somebody that it's a very straightforward presentation and they -- let's say they have very physiological depression symptoms, in other words, they feel very tired, they have very little motivation, they can't -- just can't move their body to do the things that they need to do. Provided that there isn't an underlying medical condition and that's been ruled out through interdini- -- disciplinary practice or referral, then I would say we have good reason to believe that probably about 80 percent of people would achieve remission is what we would call it for -- for a condition like that. So I could tell -- I wouldn't tell somebody, I'm absolutely confident this will cure you.

Q. Uh-huh.

A. You know, something else could happen. Their parent could die. They -- you know, any number of things could happen that could interfere with their progress, you know, but I could say, you know, given the evidence base for the success rate of this intervention, given the complexity or lack of

complexity in your presentation, you know, here's how likely I think it is you would benefit, but I would never tell somebody, I am certain that this will cure you.

Q. Okay. Let's flip to Page 20. So I'm going to -- the last sentence of Subsection B you say, Likewise, surgical intervention alone is not likely to be curative and may not substantially ameliorate her suicidality --

A. Uh-huh.

Q. -- is that right?

A. Right.

Q. Okay. So are you making a prediction here about whether a certain treatment would be curative?

A. I think it's not likely it would be curative. I do -- I think it's likely she would achieve a benefit from it. It's really -- I think the debate is sort of the degree of that benefit. Secondarily, you know, the question of, like, substantially ameliorating her suicidality, I mean, it might, you know, but I don't think that we have confidence to say it will.

Q. Do you see any tension between your assertion

here and the assertion we spoke about a moment ago that a psychologist cannot predict with confidence that a certain treatment will be curative?

A. Yes, but that's basically making -- that's saying, this is -- this is how this is going to go. What I -- what I'm saying instead here when I'm saying it's not likely to be curative is -- what I'm saying is the most likely outcome is that it's going to fall short of that particular benchmark of being curative. Doesn't mean -- I'm not saying surgical intervention alone is not likely to provide psychological benefit or amelioration of the symptoms, but it's not -- I don't think it's likely to be curative specifically. That's a very high bar.

Q. Okay. But do you think that gender-affirming surgery would provide psychological benefit to Kanautica?

A. I think depending on the circumstances, if it's provided in the way that she details, which I described in my report on Page 31, receiving medical care in the community including aftercare and wound management,

receiving care and support directly from her support network, participating in meaningful personal and professional development opportunities both while she's preparing for it and while she's recovering from it, then, yeah, I think she -- I have no problem at all saying I think it's likely she would benefit from that and probably, I think, get significant relief both with respect to gender dysphoria and with respect to suicidality.

Q. Okay. Are you familiar with the treatments for gender dysphoria she has received so far?

A. I don't want to misrepresent my level of understanding. I have some understanding of what she's already undertaken, but I don't have a medical professional's level of knowledge.

Q. Okay. Do you know that she has been on hormone therapy?

A. Yes.

Q. Okay. Do you know that she has un- -- undergone social transitioning?

A. Yes.

Q. Okay. To your knowledge, have those

treatments cured her of gender dysphoria?

A. No.

Q. Okay. Other than surgery, is there any treatment that you're familiar with for gender dysphoria that she has not received?

A. So medical treatments, I couldn't speak comprehensively to that because I'm not a medical expert so I can't tell you what all of those options would be. I don't believe that she's done voice training. That's something that she could do. There might be other kinds of sort of plastic surgery-type interventions that she might want, but, you know, those are -- you know, the -- the surgery aspects are a medical intervention. And additionally, there -- this is such an evolving area of practice that there are new procedures all the time so the options today might not be the options next year. There could be other things that would help her.

She had -- she -- and she has had plastic surgery from what I understand in terms of what I discussed with her in her deposition, but when you read her description of it and talked with her about it, she

describes getting very, very limited gains from these prior medical interventions.

Now, you know, one of the questions would be if she got such limited benefit from the prior interventions, why do we believe we're going to make the jump to a hundred with the -- one single intervention, you know? I don't think there's a -- I don't think we have good reason to believe that based on her own characterization and recollection of her experiences with medical intervention.

Q. Uh-huh. So zooming out somewhat, like, big picture, what do you believe is causing her gender dysphoria?

A. So Mrs. Zayre-Brown has had a very -- from my understanding she has not had an easy life. She does have support in her marital relationship and evidently her family relationships, but living as a transgender person in the United States at this point in time is painful and difficult not only because of constraints on access to services or people not even knowing what's available to them sometimes or not being able to afford

it, but also, obviously, there's a cultural environment that's hostile to people and I believe that that cultural environment is a significant cause and contributor to her gender dysphoria.

On top of that, frankly, our gender binary is -- is highly, highly determined by essentially the -- the ancestry's eugenics and the beauty standards for women are difficult for anybody to achieve and fairly narrow. And I think if the aim is to not be identifiable as a trans woman, that's going to -- that's difficult. And if you are identified, then it may be because of some piece of your anatomy that somebody knows about, but it could also be your height. It could be your shoulders. It could be your voice. People who aren't even trans are getting -- people are telling them that they're trans because their shoulders are too broad or their voice is too low. There are all kinds of ways in which she, I think, experiences transphobia in ways that have, frankly, nothing to do with her primary sex characteristics, but I also believe that

there is a contribution that is coming from her own internal discomfort with continuing to have a phallus when that is not consistent with her gender identity. I do think that contributes to her gender dysphoria and it makes sense then rationally that coping with that is going to be a sensible step for her in terms of treatment.

Q. And to be clear, what do you mean by coping with that?

A. Well, I mean having -- having a procedure to -- you know, having bottom half surgery, whether that's a vulvoplasty or vaginoplasty, dealing with that component of it, of the internalized transphobia. And also, just the discomfort, emotional and psychological discomfort, with continuing to have a phallus, that is its own contribution. I think that's valid. I believe her when she says that.

Q. Do you have any reason to think that Mrs. Zayre-Brown can be cured of her gender dysphoria while she still has a penis or a phallus as she calls it?

A. Based on her statements, I think not. I

believe her self-report has consistently been that this is something that she sees as sort of a keystone intervention. I think the main difference really is just that in my view, she needs other things as well and that we want to be careful and mindful about the timing and the setting and the context of intervention to maximize the benefit that she's going to get so we can get as close to the benefit as she anticipates as we possibly can.

Q. Okay. You mentioned the -- the phrase necessary but not sufficient a little while ago.

Would you say that removing her phallus and having genital surgery would be necessary but not necessarily sufficient to cure her gender dysphoria?

A. Ultimately, yes. The question of the timing, I think, is a separate issue, but in the long-term sense, yes.

Q. Uh-huh. Did you find any contraindications for surgery?

A. So I can't speak to medical contraindications for surgery. And surgery, broadly speaking,

no, but as far as what she described -- you know, that's what I keep coming back to is what she's describing as the set of circumstances that are going to -- going to give her the most relief.

Q. Do you have any reason to think that if she underwent a vulvoplasty, she would later regret it?

A. I think it's possible if the -- not in and of its- -- not, like, per se. Not only because of, oh, I wish I had had another procedure. It's possible depending how -- how the procedure went that later on, she could have some amount of regret, not that she had a vulvoplasty but that she didn't have a vaginoplasty instead. I think that's possible. I don't think it's likely that she would experience regret in terms of saying, I wish I still had a phallus.

Q. If someone undergoes a vulvoplasty, are they able to also undergo vaginoplasty later?

A. My understanding of it -- and I want to be clear because I'm not a medical professional. I can't give a medical opinion. But my in- -- understanding from consulting with

medical professionals who do the procedures is that vulvoplasty is a less commonly done procedure so it's -- most of the surgeons who would do it will have less familiarity with doing that compared to vaginoplasty and also that with respect to both the orchiectomy and vulvoplasty, there's the necessity of maintaining a certain amount of tissue and certain structures in order to be able to later do a vaginoplasty, although there are alternative procedures that can be done if that tissue isn't there, and they may be more or less desirable to the individual. I think it has to be a highly individualized medical decision that's made between the doctor and their patient.

Q. Okay. Let's turn to Page 29 of your report, please. And I'm -- it's the final sentence of the third paragraph on the page. In other words, Mrs. Zayre-Brown's acute mental health crises in recent years were indirectly rather than directly related to her gender dysphoria. Additionally, by her account, significant contributions to her distress were associated with administrative processes

and delays related to her treatment.

Did I read all that correctly?

A. Yes.

Q. What does it mean for something to be indirectly related to gender dysphoria?

A. So the idea would be that there's a certain amount of distress that comes from what I just described as this sort of compartmentalized -- it may be internalized transphobia or may be some other manifestation of just dis- -- emotional and psychological discomfort with continuing to have a body part that you don't want to have or wishing you had one that you don't. The mental health crises appear to be in part -- again, it's like that cork on the ocean thing. The gender dysphoria is going to be -- I think for her it has ebbed and flowed to some degree, but I don't think there's a time when it hasn't been present as far as I can tell. But the interactions with authority figures who give her bad news, who she perceives as delaying things, or when she has feelings of abandonment, that also taps into, I think, some trauma-related issues

that get at abandonment and rejection and I think that also triggers these acute mental health crises, which doesn't mean that, oh, you just solve the trauma problems and you won't have any more of those acute mental health crises. All it means is that we need to have an integrated care/treatment plan that accounts for both the gender dysphoria and what's needed for that but also managing the mood symptoms and the trauma symptoms.

Q. And when you say delays here, what delays are you referring to?

A. So this is -- you know, it says, by her account.

Q. Uh-huh.

A. So this is -- what she's telling me is that she felt that there were times that she wasn't getting enough information about what the status was of things that were happening, that it took too long to schedule consultations or even find out whether one would be scheduled, that she would get anxious waiting for decisions to come in. So these are things that she was telling me were the source of distress for her.

Q. Okay. Do you believe that those delays happened?
A. I don't have any reason to think that her subjective perspect- -- perspective as related to me is not accurate. I don't think she misrepresented her perspective. Whether or not it's objectively true that there were delays I can't speak to because those are administrative processes and I don't know if they, you know, occurred in a -- according to some set of time lines that they were supposed to abide by.
Q. Okay. But you don't have any reason to not believe Kanautica that those delays happened?
A. I believe that from Kanautica's perspective, it has absolutely been a process that has been marked by delay and disappointment.
Q. Right. My question is more in terms of whatever objectively happened.
A. Uh-huh.
Q. Do you have any reason to believe that something other than what Kanautica told you happened?
A. Oh, no.
Q. Okay. Do you believe that those delays

caused her distress?

A. So it's hard to differentiate between the delays themselves and getting news about things because when you look at the pattern for her, it does appear that when she's having the more acute distress, it's not after some long period of time has gone by. It's more like she got news from somebody is often -- she described in her interview with me, for example -- I think it was Dr. Hahn came and told her bad news and so it wasn't just that she had waited. It wasn't the delay. It was the -- from her perspective getting this news and also feeling unsupported afterwards. Same thing, I think, when she had to go to the hospital and then she came back and she had to go into restrictive housing.

So some of that is certainly distress about getting news that she didn't want, feeling disappointed and hopeless, I think, but also, she was distressed as well about having to return and then go into restrictive housing.

Q. And the distress that she experienced, is

that because she would continue to have a phallus?

A. I think some of it is -- yeah, I think that's absolutely part of it for her. I just don't think it's a hundred percent of it.

Q. Okay. All right. Let's turn back to Page 34, please. All right. I'm looking at Conclusion Number 3. My evaluation of Mrs. Zayre-Brown did not reveal any significant findings in her mental state that would counsel in favor of the surgery as an immediate intervention to be conducted in a prison setting from a psychological standpoint.

Did I get all that right?

A. Yes.

Q. Okay. What do you mean by immediate intervention?

A. I would say as sort of like a -- something that needs to happen in the next couple of months in that setting given her set of circumstances. Now, that's separate from the question of whether she'll benefit from it. I think she would benefit from it, but in terms of it needing to be an acute -- an

immediate intervention, we would typically be thinking of that as more of an acri- -- a crisis -- active crisis situation.

Q. Okay. Is there a time frame that you have in mind that would be more appropriate than -- well, let me rephrase that question.

Did you have -- make any findings that would counsel in favor of the surgery, you know, if not a couple months from now, then, I don't know, three or four months from now?

MR. RODRIGUEZ: I'm going to object to the form. You can answer.

A. So this is -- you know, if you read the sentence it says, an immediate intervention to be conducted in a prison setting from a psychological standpoint. So that's given that she's going to continue to remain incarcerated. So it's that particular set of in- -- of circumstances. So in -- in a prison setting immediately, like, in the next couple of months, three months, four months, that would still be fairly immediate because there's a period of preparation she'll have to undertake. She -- she couldn't have it tomorrow. You know, she would have -- she

has a certain amount of preparation she would have to undertake anyway. But what she indicated when I interviewed her is that simply knowing either that she's going to have surgery and it's scheduled -- and she didn't give a time frame for that. She didn't say within the next year. She just said scheduled. And then also the issue of, you know, having a plan for the reentry program that she wanted to enter into. She indicated that those things would really significantly alleviate her distress and so based on her account, that pushes back against the notion that it needs to be immediate. What she's telling us is that there are other things that we can do now that would give her significant relief, plans that we can make, you know, placements that she could go to potentially based on her account but that those are the kinds of things that are going to factor into how she's feeling.

So, in other words, it's not getting the surgery. It's having a future where she sees herself being able to get the surgery that

she wants. And the future that she describes as being best for her and most psychologically beneficial for her is the one that -- I mean, I don't want to be redundant, but we've already gone over it a couple of times in the report.

Q. So if Kanautica were out in the community right now and you were treating her as -- as your patient, would you recommend immediate surgery?

A. I don't know. I mean, she would have -- I'd have to evaluate her. You know, the other thing is that there is a -- the reentry is not stress free for people. Even though it's a positive event, it's also highly stressful. So, you know, I think she's anticipating it in a positive way. I think ultimately, she'll have significant positive mental health benefits from release, but I think she'll also -- you know, when I assessed her she was in prison and I think she would probably just need a follow-up. I would give her a couple of weeks to -- to adjust so that the assessment wasn't looking at just, like, a -- you know, sort of disorientation from

reentering the community, but she also hasn't been locked up for that long so I think that could probably be a pretty brief discussion with her just to make sure that her mood is okay is the primary thing, that that's not dysregulated in some way. But as far as in the community, I don't see any reason why she wouldn't be suitable for surgery in whatever time frame she and her treating providers deemed appropriate.

Q. Okay. And in your view, is it her being incarcerated that makes her unsuitable or less suitable for surgery now?

MR. RODRIGUEZ: Objection to form. You can answer.

A. It's not the incarceration so much as the timing. So she is due for release in a relatively short amount of time. And it's relevant also specifically with respect to the suicidality benefit because people who have less than 18 months left to serve on their sentence -- that's kind of the dividing line. If you look at the research on suicide in incarcerated folks, people who have less than 18 months, then you see a decrease in

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their suicide risk. 18 months forward you have a -- what we call a dose-dependent effect where the more time they have to serve, the more suicidal they -- more likely it is that they'll die by suicide.

So for her, it is an issue of timing in the fact that she doesn't have a lot of time left. If she did have a lot of time left, her mental state might also be different if she wasn't anticipating release, you know, so I think it's hard to sort of forecast how she might look different if she had more time ahead of her.

Q. Do you know if there's any risk in delaying gender-affirming care for someone with gender dysphoria?

A. Yes, I mean, absolutely. But gender-affirming care is a very broad category. Gender-affirming care can be using somebody's name.

Q. Okay. Well, then I'll be more specific. Gender-affirming surgery. If someone is a candidate for gender-affirming surgery, is there -- specifically genital surgery, is there any risk in delaying that treatment?

MR. RODRIGUEZ: I'm going to object, vague, but you can answer.

A. There are some individuals who I think would be harmed by that, yes, but I also think it has to be an individualized determination.

Q. And what kind of person would be harmed by that?

A. So this gets -- this is a difficult kind of question to answer because I think that there are a lot of circumstances about institutional environments that put trans people in a difficult position. If you say, well, it's the people who are attempting autocastration or autopenectomy, then what that does is that incentivizes people to feel like that's something I need to do in order to be able to get care so I'm always very cautious about talking about that. But certainly, people who are actively self-mutilating, self-injuring, or making attempts, which, you know, the -- that's concerning. The issue is always going to be, though, how much benefit are they going to get from purely the surgical intervention versus a full treatment plan that encompasses

other components of whatever it is that they're dealing with because, like I said, most trans people, they have other things going on in their life that are -- you know, trauma in particular is so common that -- and -- and they're also at high risk in -- in carceral facilities. You know, PREA acknowledges that. So, you know, it's complicated and make -- does make it very difficult to answer these hypotheticals for that reason.

Q. Uh-huh. Okay. So I understand, and correct me if I'm wrong, but that in your view, undergoing surgery while she's in prison would be far from ideal for Kanautica.

Is that fair to say?

A. Yes, by her own account.

Q. Okay. If she were to undergo a vulvoplasty in prison, do you think it is likely or unlikely that she would receive psychological benefit?

A. I think it's likely she would get some degree of psychological benefit. I would definitely fall short of saying it would be curative or something close to curative because I think

there are a number of other factors. But would she get some psychological benefit from it? Provided that it went okay and she didn't have significant surgical complications, which is entirely possible and could cause all kinds of issues, then I think she would get some benefit from it. I think that's likely. I think even just finding out that she's going to get the surgery, whe- -- you know, in the community or elsewhere, I think that give -- also would give a benefit.

Q. Does it give the same benefit?

A. In the longer-term sense, likely, no. But in the short-term sense, probably, actually, there wouldn't -- I don't know that there would be that much difference. And, in fact, she might have more stability in terms of the benefit of having something scheduled because of the potential disruption that the medical process itself could cause for her.

Q. Okay.

MR. SIEGEL: Let's go off the record.

(Whereupon, there was a recess in the proceedings from 1:19 p.m. to 1:25 p.m.)

MR. SIEGEL: All right. We have no

more questions at this time.

THE WITNESS: Okay.

MR. RODRIGUEZ: All right.

MR. SIEGEL: Anything?

MR. RODRIGUEZ: No. No, we're good.

[SIGNATURE RESERVED]

[DEPOSITION CONCLUDED AT 1:25 P.M.]

A C K N O W L E D G E M E N T O F D E P O N E N T

I, SARA BOYD, PH.D., declare under the penalties of perjury under the State of North Carolina that I have read the foregoing 183 pages, which contain a correct transcription of answers made by me to the question therein recorded, with the exception(s) and/or addition(s) reflected on the correction sheet attached hereto, if any.

Signed this, the _____ day of _____, 2021.

_____

SARA BOYD, PH.D.

State of:_____

County of:_____

Subscribed and sworn to before me this _____ day of _____, 2023.

_____

Notary Public

My commission expires:_____

E R R A T A S H E E T

Case Name: Kanautica Zayre-Brown vs. The North Carolina Department of Public Safety, et al.

Witness Name: Sara Boyd, Ph.D.

Deposition Date: August 4, 2023

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Signature Date

STATE OF NORTH CAROLINA)
) C E R T I F I C A T E
COUNTY OF WAKE)

I, LISA A. WHEELER, RPR, CRR, Stenographic Court Reporter and Notary Public, the officer before whom the foregoing proceeding was conducted, do hereby certify that the witness whose testimony appears in the foregoing proceeding was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter transcribed by me; and that the foregoing pages, inclusive, constitute a true and accurate transcription of the testimony of the witness.

I do further certify that I am neither counsel for, related to, nor employed by any of the parties to this action and, further, that I am not a relative or employee of any attorney or counsel employed by the parties thereof, nor financially or otherwise interested in the outcome of said action.

This the 17th day of August, 2023.

_____

Lisa A. Wheeler, RPR, CRR

Notary Public #19981350007